No. 88-2043

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

GERALD L. BALILES, *et al.*,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, NATIONAL COUNCIL ON THE AGING, INC. AS *AMICI CURIAE* ON BEHALF OF RESPONDENT

(Additional *Amici Curiae* Listed in Appendix)

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QUESTION PRESENTED

Whether 42 U.S.C. § 1983 affords hospitals and nursing homes participating in a State Medicaid program a cause of action against State Medicaid officials for violation of the federal standard for Medicaid reimbursement of such institutions?

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INTEREST OF *AMICI CURIAE*

Amici are an alliance of national organizations representing health care providers that participate in the Medicaid program, and recipients of medical assistance under that program. *Amici*'s shared interest in this case is their concern that States not adopt Medicaid Plans designed systematically to under-reimburse providers, and thereby jeopardize Medicaid recipients' access to quality health care. *Amici* recognize that assuring high quality hospital and nursing home services is a complex process, requiring the hard work and cooperation of many dedicated health care professionals and nonprofessional staff. *Amici* also know that there is a vital link between

the ability of providers to assure the availability to patients of high quality care and the adequacy of the payment they receive for such care. Because Medicaid dollars represent approximately 10 percent of the gross revenues of hospitals, and 43 percent of the gross revenues of nursing homes, *amici* believe that providers must have the means to assure that the federal standard for Medicaid reimbursement of such institutions is met by each State's Medicaid program.

Amicus American Health Care Association ("AHCA") and its affiliated State associations are the largest national trade association representing the long term care (nursing home) industry. AHCA is a private, voluntary, nonprofit federation of 51 affiliated State associations representing more than 10,000 nonprofit and for-profit long term care providers which care for over one million nursing home patients. Many such patients are funded under the Medicaid program, and Medicaid spends annually approximately $40 billion (State and federal funds) on nursing home services for Medicaid recipients. Founded in 1949, AHCA remains dedicated to the promotion of standards for professionals in long term health care delivery and quality care for residents.

Amicus American Hospital Association ("AHA") is a private, voluntary, nonprofit, national trade association of hospitals whose mission is to promote the welfare of the public through leadership and assistance to its members in the provision of better health care and services. With approximately 5,500 institutional members, the AHA represents a majority of the nation's acute care hospitals. A significant majority of these hospitals participate in the Medicaid program. Because more than $23 billion of services are provided by hospitals to Medicaid patients annually, the AHA is vitally concerned that the payment systems implemented by the States provide rates that are adequate to guarantee access to quality medical care for those served through the Medicaid program.

Amicus American Association of Homes for the Aging ("AAHA") and its affiliated State associations are a national nonprofit trade association representing over 3,500 not-for-profit facilities providing health care, housing, continuing care retirement programs, and community services to more than 500,000 older individuals. Seventy-five percent of AAHA homes are affiliated with religious organizations; the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions and community groups. With strong community involvement and long-standing community ties, AAHA members are committed to meeting the physical, social, emotional and spiritual needs of their residents in a manner which enhances each resident's sense of self-worth and dignity. Most of the members represented by AAHA and its 37 State affiliates participate in the Medicaid program.

Amicus National Council on the Aging, Inc. ("NCOA"), founded in 1950, is a national, nonprofit organization. Its membership includes individuals, voluntary agencies and associations (social, health, education, housing, religious, civic, etc.), business organizations and labor unions united by a commitment to the principle that the nation's older people are entitled to lives of dignity, security, physical, mental and social well-being and to full participation in society. NCOA conducts research, undertakes demonstration programs, sets standards, disseminates information and promotes the development of a continuum of opportunities and quality services with, by, for, and to older persons. NCOA has over 7,000 members, including nonprofit adult daycare programs, community-based long term care organizations, senior housing sponsors and other providers of services to the elderly.

The decision of the Court of Appeals in this case, recognizing that the Medicaid statute does not withdraw from hospitals and nursing homes a cause of action under 42 U.S.C. § 1983, allows health care providers the essential right to sue State Medicaid officials to vin-

dicate the right to reimbursement through payment rates that satisfy the federal standards contained in the Medicaid statute. Without the opportunity for federal judicial review, the quality of care that hospitals and nursing homes are able to provide is likely to suffer in many States. Because they believe that this result would be contrary to the purposes of the Medicaid statute and to the best interests of Medicaid recipients, *amici* wish to present their views concerning the important issues presented by this case.[1]

BACKGROUND ON THE MEDICAID PROGRAM AND STATE RATESETTING METHODOLOGIES

A. The Medicaid Program

Medicaid is a cooperative federal-State program whose purpose is to provide federal funding to States to assist them in furnishing medical assistance, rehabilitation, and other services to the indigent. 42 U.S.C. § 1396 (1982 & Supp. 1987). Like other federal-State programs, States may choose between complying with the conditions of the statute or foregoing federal funding. To participate in the program, a State must first establish a State Plan for medical assistance ("State Plan"). *Id.* The State Plan is defined by regulation as a comprehensive written statement that describes the nature and scope of the State's Medicaid program and conforms with the requirements of the Medicaid statute, regulations, and other official issuances of the Department of Health and Human Services ("HHS"). 42 C.F.R. § 430.10 (1988).

The federal statutory requirements that a State Plan must meet are set forth in section 1902 of the Social Security Act. 42 U.S.C. § 1396a (1982 & Supp. 1987). The operative language of section 1902 is mandatory—the section begins with the statement, "A State Plan for medical assistance must provide . . .," and proceeds to enumerate 50 requirements. Among these requirements is

[1] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

the federal standard for reimbursement of hospitals and nursing homes, commonly known as the Boren Amendment. 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. 1987).[2] This provision states that:

> a State Plan for medical assistance *must* provide for payment . . . of the hospital services, skilled nursing facility, and intermediate care facility services . . . provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

Id. (emphasis supplied).

At the federal level, Medicaid is administered on behalf of HHS by the Health Care Financing Administration ("HCFA"). HCFA regulations implementing the Boren Amendment require that the State Plan specify comprehensively the methods and standards used by the State Medicaid agency to set payment rates that are consistent with federal Medicaid requirements. 42 C.F.R. § 447.252 (1988). In addition, executing the statutory mandate, the regulations require that the State make certain findings on an annual basis, and whenever it submits a Plan or amendment for approval. 42 C.F.R. § 447.253(b) (1988). Among the findings required is that the State

[2] Section 1902(a)(13)(A) of the Social Security Act. Congress originally applied the Boren Amendment only to nursing homes in the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962 (1980). The new payment standard was extended to hospital services in the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173 (1981). Congress has made clear that its intentions regarding the payment standard in the hospital amendment are identical with respect to the nursing home amendment. S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981).

pays hospitals and nursing homes rates that comply with the Boren Amendment standard. 42 C.F.R. § 447.253(b)(1) (1988).

The State is also required to provide assurances satisfactory to HCFA that it has made the requisite findings, 42 C.F.R. § 447.253(a) (1988), and that it provides an administrative appeals procedure. 42 C.F.R. § 447.253 (a), (c) (1988). States are not required to submit the findings themselves, or supporting data, for review. HCFA's review thus does not determine whether a State's Plan in fact complies with the Medicaid statute's substantive standards, but is limited to determining whether the State has submitted satisfactory "assurances" of its compliance with those standards. Pursuant to these authorities, all States have opted to participate in Medicaid, as has the District of Columbia.[3]

B. Enforcement of State Plans

HCFA regulations provide two basic means through which HCFA is permitted to enforce the obligations that the statute places upon participating States. First, in order to receive federal funding, every State Plan, and every amendment to a State Plan, must be approved by HCFA, which is authorized to disapprove those Plans that do not meet federal requirements. 42 C.F.R. §§ 430.12-430.15 (1988). Second, even after a Plan has been approved, HCFA has the authority to withhold federal payments to the State if HCFA finds that the State Plan, in operation and practice, does not comply with the requirements of section 1902, including the Boren Amendment. Specifically, the statute and regulations allow HCFA to withhold payment upon a finding:

[3] The State of Arizona does not currently participate in Medicaid, but rather in a HCFA-sponsored demonstration project called the Arizona Health Care Cost Containment System. This program is the functional equivalent of Medicaid, and is treated herein as a Medicaid program.

> (1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [section 1396a]; or
>
> (2) that in the administration of the plan there is failure to comply substantially with any such provisions.

42 U.S.C. § 1396c (1982 & Supp. 1987); see also, 42 C.F.R. § 430.35(a) (1988). The regulations further specify that "a question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the Plan itself complies with that requirement." *Id.* at § 430.35(c).

In addition, the regulations require HCFA to perform "program reviews . . . [i]n order to determine whether the State is complying with the Federal requirements and the provisions of its Plan," *id.*, § 430.32(a), and States must correct their deficiencies. *Id.*, § 430.32(c). Although these provisions grant HCFA authority to terminate noncomplying States from Medicaid participation, the agency has never exercised this authority.

C. State Ratesetting Methodologies

The Boren Amendment grants States flexibility to fashion various reimbursement systems, as long as the federal standards spelled out in the statute are satisfied. While States have in fact adopted a variety of reimbursement systems, all are variations on one of two themes: specifically, they are either retrospective or prospective. In a retrospective system, the State sets interim rates that are adjusted after the end of the cost year based on the facility's cost report (a detailed financial statement) for that period. In a prospective system, rates are set based on an estimate of costs for a rate period, and there is generally no retrospective adjustment to account for actual facility costs during that period. By far the more common type of system, and the one at issue in this case, is the prospective system.

The hospital ratesetting methodology in Virginia's State Plan contains many elements found in other prospective

payment systems, and serves to illustrate the various components which make up such systems. See J.A. 24-45. See generally, *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891, 895-96 (E.D. Va. 1985) (describing operation of Virginia's system). Hospitals are categorized into peer groupings based on their number of beds and whether they are located in an urban or rural area.[4] For each group of hospitals, a reimbursement ceiling on operating costs was established for the initial rate period, based on cost data from the prior year (*i.e.*, base year), adjusted for inflation with a "reimbursement escalator." Other States call this adjustment factor a "trend factor" or "inflation factor," but in any case, its purpose is to account for cost increases between the base year and the period during which the rates are actually paid.

In Virginia, the State also made further adjustments to account for wage differentials between various geograpic areas throughout the State. These ceilings became the reimbursement limits for calculating individual facility rates. Each facility was entitled to a rate based upon its base year costs adjusted for inflation, but no facility could receive a rate higher than the ceiling. In subsequent years, the facility's rate continued to be computed by application of the trend factor to the base year costs, rather than by recalculating allowable costs.

The extent to which hospitals or nursing homes are reimbursed their actual costs thus may vary widely from State to State, and within a State, depending on the rate-setting methodology adopted in the State Plan. In every case, however, the State is required to make annual findings, and to assure HCFA, that the rates established by the chosen methodology are "reasonable and adequate to meet the costs which must be incurred by efficiently and

[4] Other factors sometimes considered by States in establishing hospital peer groupings are the age of the facility, teaching status, and the like. In setting nursing home rates, States may use similar groupings, and in addition, nursing homes are grouped by level of care provided, *i.e.*, skilled nursing facilities and intermediate care facilities.

economically operated facilities" in order to make available quality care to Medicaid recipients. 42 U.S.C. § 1396a (a)(13)(A); 42 C.F.R. 447.253 (1988). The issue presented by this litigation is whether facilities have a right to sue State Medicaid officials under section 1983 to assure that the Plan's ratesetting methodology does not systematically fail to conform with this standard.

SUMMARY OF ARGUMENT

Beneficiaries of rights conferred by a federal statute have a cause of action under 42 U.S.C. § 1983 against State officials for violation of those rights. *Maine v. Thiboutot*, 448 U.S. 1 (1980). This rule permits the beneficiaries of a federal funding program to sue State officials for violations of federal funding requirements in their administration of the program, unless the defendants demonstrate either that: (1) Congress did not intend the statute at issue to confer "enforceable rights" on the plaintiffs; or (2) Congress did intend remedial devices required by the statute to constitute a comprehensive and exclusive scheme to remedy violations. *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987).

Under neither of these exceptions is there a basis for finding congressional intent to withdraw the section 1983 remedy from hospitals or nursing homes seeking to enjoin violations of the federal payment standard established by the Boren Amendment. The enforceable rights exception applies only where Congress speaks in merely precatory, rather than mandatory terms, or plainly does not intend the statute to confer rights on the putative plaintiffs. In the instant case, the payment standard set by the Boren Amendment is unequivocally mandatory, based on its plain language and because compliance with the standard is an express condition on the continued receipt of federal Medicaid funds. Moreover, the structure and legislative history of the Medicaid statute and the Boren Amendment indicate that Congress, recognizing an essential link between adequate reimbursement and quality of

care, intended the payment standard to benefit providers as a way of assuring the availability of quality services to Medicaid recipients.

Nor did Congress intend the administrative appeals procedures established by the States pursuant to HCFA regulations to represent a comprehensive scheme that would be the exclusive remedy for violations of the Boren Amendment. Not only is a comprehensive appeals requirement not directly mandated by the statute, but the regulations require only that States furnish an appeals or exceptions procedure to permit an individual provider an opportunity to present new evidence and receive prompt administrative review of its payment rate. HCFA has never suggested that the appeal procedures are intended for review of the legality of the State's ratesetting methodology, and the overwhelming majority of States, with the approval of HCFA, have adopted procedures that preclude such challenges. In short, there is no evidence that Congress intended the Medicaid statute as a comprehensive or exclusive remedial scheme, and the individual provider rate appeal regulation adopted by HCFA cannot change that intent.

Finally, the cursory nature of the review of State Plans that HCFA conducts makes a private cause of action essential to effective enforcement of the federal payment standard in the Boren Amendment. Lower court decisions invalidating State ratesetting methodologies for noncompliance with the Boren Amendment demonstrate the need for such a remedy. Several of these cases show that States have often implemented State Plans whose noncompliance with the statute is egregious. In the absence of a private cause of action to enjoin noncompliance, such Plans would operate to deny providers the reasonable and adequate reimbursement needed to assure the availability of quality care to Medicaid recipients.

ARGUMENT

RESPONDENT HAS A CAUSE OF ACTION UNDER 42 U.S.C. § 1983 AGAINST STATE OFFICIALS FOR VIOLATION OF THE FEDERAL MEDICAID REIMBURSEMENT STANDARD IN THE BOREN AMENDMENT

I. A SECTION 1983 ACTION EXISTS FOR VIOLATIONS OF FEDERAL STATUTORY RIGHTS UNLESS CONGRESS INTENDED NOT TO CONFER ENFORCEABLE RIGHTS UPON THE PUTATIVE PLAINTIFF, OR INTENDED A COMPREHENSIVE AND EXCLUSIVE REMEDIAL SCHEME IN THE ENACTMENT ITSELF TO SUBSTITUTE FOR SECTION 1983

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that beneficiaries of an entitlement created under the Social Security Act could sue State officials under 42 U.S.C. § 1983 for alleged deprivation of benefits conferred under the Act.[5] Since *Thiboutot*, the Court has recognized two exceptions to the rule that section 1983 is available to remedy State violations of rights secured by federal statutes. See *Middlesex County Sewerage Authority v. National Sea Clammers Association*, 453 U.S. 1, 19 (1981), citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 67 (1981). A plaintiff alleging a deprivation of federal statutory rights by State officials will not be permitted to sue under section 1983 if: (1) the statute at issue is not the kind that creates enforceable "rights" under section 1983; or (2) Congress has

[5] The program at issue in *Thiboutot* was Aid to Families With Dependent Children ("AFDC"), a federal-State cooperative funding program very similar to Medicaid. In both, the federal government contributes funds to be administered by a State agency in accordance with the terms of a State Plan approved by the supervising federal agency. *Compare* 42 U.S.C. § 602(a); 45 C.F.R. §§ 201.2-201.3 (AFDC), *with* 42 U.S.C. § 1396a(a); 42 C.F.R. §§ 430.10-430.15 (Medicaid). Like the plaintiffs in *Thiboutot*, Respondent seeks only a mechanism to compel State Medicaid officials to comply with statutory standards governing expenditure of program funds.

foreclosed private enforcement of the statute by creating a comprehensive and exclusive remedial scheme in the enactment itself. *Sea Clammers*, 453 U.S. at 19. The State defendants bear the burden of demonstrating, "by express provision or other specific evidence from the statute itself that Congress intended to foreclose private enforcement." *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).[6]

These exceptions are inapplicable in the instant case. The language, legislative history, and agency interpretation of the Boren Amendment amply demonstrate that it creates a right to "reasonable and adequate" reimbursement that is "enforceable" within the meaning of *Pennhurst*, and that the statute contains no remedial mechanisms that are sufficiently "comprehensive" to demonstrate that Congress intended to foreclose access to section 1983.

A. The Medicaid statute creates an "enforceable right" to provider reimbursement by rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities

The first of the *Pennhurst* exceptions to section 1983 examines the statute, under which the plaintiff claims a right, to determine whether Congress intended that enactment to impose an "enforceable" obligation on the

[6] Petitioners repeatedly mistake the object of the *Pennhurst* test as determining whether a cause of action under section 1983 is "implied." Pet. Br. at 7, 11, 17, 21, 22. Petitioners have confused *Pennhurst* analysis with that applied by the Court in determining whether a cause of action should be inferred from a silent federal statute. *E.g.*, Cort v. Ash, 422 U.S. 66 (1975). In the latter case, a plaintiff must demonstrate that Congress intended by implication to confer a private right of action. Section 1983, however, is an express cause of action. The relevant inquiry is whether there is evidence that Congress intended to withdraw that cause of action in a particular case. See *Sea Clammers*, 453 U.S. at 26 (Stevens, J., concurring in part and dissenting in part); West Virginia University Hosps., Inc. v. Casey, 885 F.2d 11, 18 & n.1 (3d Cir. 1989).

State defendants. *Pennhurst*, 451 U.S. at 15. In the instant case, this inquiry has two components. First, the Court must ask whether Congress intended the interest in reasonable and adequate rates of payment to be mandatory, or whether Congress spoke "merely in precatory terms." *Id.* Second, if the statutory provision is a mandatory one, it must be asked whether the provision was intended to benefit Medicaid providers. *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 5 (U.S. Dec. 5, 1989).

1. In *Pennhurst*, the Court concluded that the patient "bill of rights" provision in the Developmentally Disabled Assistance and Bill of Rights Act of 1975 was merely a declaration of policy rather than a mandatory condition for participation in the program. The Court contrasted the Bill of Rights provision, which appeared in a section of the Act entitled "Findings," with other provisions of the Act entitled "conditions." 451 U.S. at 19, 23. While the failure of a State to meet one of the conditions of the Act could lead to the loss of federal funds, "funds [could] not be terminated for a State's failure to comply with" one of the "findings." *Id.* at 23. The distinction between conditions of receiving funds and mere findings of policy was critical, the Court explained, because only if Congress clearly "impose[d] conditions on the grant of federal funds" could "the States knowingly decide whether or not to accept those funds." *Id.* at 24. By contrast, in *Wright*, the statutory provision at issue was framed in "mandatory" terms, 479 U.S. at 430, and a failure to comply with that provision was enforceable by the termination of further federal funds. *Id.* at 424.

Pennhurst and *Wright* establish that a provision of a funding statute creates an enforceable right where that provision constitutes a *condition* of receiving federal funds, and where noncompliance with the provision would permit the administering federal agency to terminate further federal funding under the program. When the adminis-

trative agency retains that power, compliance with the federal standard is a "condition" on the continued receipt of such funds, and the condition is obviously enforceable within the meaning of *Pennhurst*. 451 U.S. at 23. The federal standard in the Boren Amendment is clearly a "condition" of participation. The Boren Amendment is one of 50 enumerated requirements of section 1902 which a State "must provide," and the failure to comply with any of these requirements is grounds for termination of federal funding.

Petitioners and the Solicitor General argue that because the Boren Amendment refers to rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable," the obligations of the State are complete once the Secretary accepts the assurances. This interpretation elevates form over substance, and is therefore flatly inconsistent with the statute and implementing regulations. The Medicaid statute and regulations expressly distinguish between formal compliance and compliance in practice: "a question of noncompliance in practice may rise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement." 42 C.F.R. § 430.35(c); see 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(a). The regulations further specify that a State must make annual findings that its payment rates are reasonable and must submit information related to the findings to HCFA. 42 C.F.R. §§ 447.250-447.255. There can be no doubt that if the Secretary determined, despite the State's "assurances," that the State's Plan operated in practice systematically to deny providers reasonable payment, HCFA would have the authority under the Medicaid statute to terminate federal funding. 42 U.S.C. § 1396c.[7]

[7] The Solicitor General notes that in 1988 alone, $29 billion in federal funds were expended under Medicaid. Br. of United States at 2. It is not credible that Congress would have committed the federal government to annual expenditures of this magnitude without intending that the responsible agency at least retain the ultimate authority to expel noncomplying States from participation. The fact that HCFA has never exercised this draconian authority cannot be equated with an absence of congressional intent to grant it.

The legislative history confirms the plain language of the statute. While *amici* will not attempt to provide a comprehensive review of the legislative history, the following points are particularly significant.

First, when Congress enacted the Boren Amendment, it codified the requirement for reimbursement of the costs of "efficiently and economically operated" facilities already contained in HCFA regulations implementing the prior reasonable cost-related payment standard. *See* 45 C.F.R. § 250.30(a)(3)(iv) (1976). Legislative history regarding that prior standard—in which Congress observed that "providers can continue . . . to institute suit for injunctive relief in State or Federal courts, as necessary"—thus shows that Congress did not intend the Boren Amendment to withdraw the previously available section 1983 remedy. See H.R. Rep. No. 1122, 94th Cong., 2d Sess. 7 (1976); S. Rep. No. 1240, 94th Cong., 2d Sess. 4 (1976). Moreover, notwithstanding the greater flexibility granted to the States under the Boren Amendment, legislative history to that provision itself clearly indicates that "the Secretary [of HHS] is not expected to approve a rate lower than the applicable *legal requirements would mandate*." H.R. Rep. No. 1479, 96th Cong., 2d Sess. 154 (1980) (emphasis supplied). There is no evidence that, in enacting the Boren Amendment, Congress (which was well aware of Medicaid rate litigation in federal courts) intended to withdraw providers' right to initiate such litigation.

Congress has continued from time to time to express its view that the payment standard in the Boren Amendment is mandatory. For example, when Congress enacted extensive and costly nursing home quality of care reforms in the Omnibus Budget Reconciliation Act of 1987, it specifically directed that States must take those costs into

account in setting Medicaid rates. Pub. L. No. 100-203, 100th Cong., 1st Sess., § 4211(b) (1987). Moreover, Congress required special advance review by HCFA of State Plan amendments implementing these provisions. *Id.*; see also, H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 703-704 (1987). Congress accomplished this without making any change in the underlying payment standard requiring "reasonable and adequate" rates. In addition, in enacting new federal minimum wage legislation this term, members of Congress confirmed the mandatory nature of the Boren Amendment's payment standard, stating that Medicaid "*requires* States to adjust their nursing home reimbursement rates to accommodate the increased costs that nursing homes [will] incur in complying with the increase in the minimum wage." 135 Cong. Rec. H7870 (November 1, 1989) (remarks of Representative Waxman, Chairman of Subcommittee on Health and Environment, House Energy and Commerce Committee) (emphasis supplied). See also, 135 Cong. Rec. S15249 (November 8, 1989) (remarks of Senator Hatch).

Accordingly, the Boren Amendment's federal payment standard is an "enforceable right" within the meaning of section 1983, as interpreted in *Pennhurst* and *Wright*.

2. Petitioners and their *amici* have argued that this case may be distinguished from *Thiboutot*, where the plaintiffs were a family eligible for AFDC benefits. Petitioners contend that the Medicaid statute was intended by Congress to benefit only the needy who receive medical care, not the health care providers who furnish that care. Petitioners' argument is at odds with the plain terms of the Medicaid statute, as well as its interpretation by HCFA.

The Medicaid statute makes hospitals and nursing homes direct beneficiaries of its payment provisions. First, in the case of hospitals and nursing facilities, payment is always made directly to the provider. See 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. 1987); 42 C.F.R. § 447.250. See also, 42 C.F.R. § 447.253(c) (individual provider has right to appeal its payment rate); 42 C.F.R. § 447.205 (1988) (public notice required of change in ratesetting methodology). Moreover, the Boren Amendment specifically emphasizes the need for States to establish rates adequate to permit "facilities" to meet their responsibilities to provide quality care and to afford reasonable access to Medicaid recipients. Thus, under the plain terms of the statute, providers are recognized "beneficiaries" of the Boren Amendment.

Providers' status as independent beneficiaries under the Medicaid statute is a necessary concomitant of the way the program is structured. *Amici* acknowledge that the fundamental purpose of the Medicaid program is to provide funds whereby States may arrange for the furnishing of medical assistance to the needy. But Congress recognized that this purpose could not be fulfilled without due regard for the providers' interest in adequate reimbursement. Thus, in the legislative history, Congress stated expressly that, although the Boren Amendment grants States greater flexibility in setting rates, the statute must not "encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979). See also, 42 U.S.C. § 1396a(a)(22)(D) (1982 & Supp. 1987) (State Plan must specify standards and methods State will use to assure that services are of high quality); 42 C.F.R. § 440.230 (1988) (service must be of sufficient amount, duration, and scope reasonably to achieve its purpose).[8] Thus, the effort to parse the interests of Medicaid recipients from those of providers is as inconsistent with congressional intent as it is with common sense.

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[8] Numerous lower court decisions also have recognized this connection. *E.g.*, Thomas v. Johnston, 557 F. Supp. 879, 903-04 (W.D. Tex. 1983) ("[t]he link between the adequacy of reimbursement rates paid to providers and the adequacy of care provided to Medicaid recipients is quite obvious").

B. Congress has not foreclosed private enforcement of the Boren Amendment by providers in the Medicaid statute itself

The second *Pennhurst* exception to section 1983 examines the statute under which the plaintiff claims a right to determine if the enactment contains a remedial scheme "sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. More precisely, the Court must inquire "whether Congress intended that the remedies in the substantive statutes be exclusive." *Id.* at 28 (Stevens, J., concurring in part and dissenting in part), *citing Pennhurst*, 451 U.S. at 28.

In only two cases has this Court found a statute's internal remedial schemes sufficiently comprehensive to demonstrate congressional intent to make the schemes exclusive. In *Sea Clammers*, the Court held that the "unusually elaborate enforcement provisions" of two federal water quality statutes, conferring private judicial remedies on citizens, evidenced congressional intent to preclude a section 1983 remedy. 453 U.S. at 13-14. A statutory right to judicial review was also available in *Smith v. Robinson*, 468 U.S. 992, 1011 (1984).

By contrast, the Court noted the complete absence of a private judicial remedy in concluding that the statute at issue in *Wright* was not intended to be exclusive. 479 U.S. at 427. The similar failure of Congress to provide any private judicial remedy under Medicaid strongly suggests the same result here. In fact, the Boren Amendment itself is silent as to the requirement of any private judicial or administrative remedies.[9]

[9] *Amici* the National Governors' Association *et al.*, erroneously argue that 42 U.S.C. § 1396a(a)(37)(B) requires States to establish administrative appeals procedures for providers. Br. of National Governors' Association, *et al.*, at 5. This section, which requires States to establish "procedures for prepayment and post-payment *claims* review" (emphasis supplied), by its plain terms has no bearing on provider appeal rights. Enacted as part of the Medicare and Medicaid Anti-fraud and Abuse Amedments of 1977, Pub. L. No. 95-142, § 2(b), this section relates to the *internal procedures* which States must establish to review specific claims to assure the medical necessity and quality of services provided to Medicaid recipients. It is especially revealing that HCFA, in adopting the regulations for limited appeals under the Boren Amendment, has not cited 42 U.S.C. § 1396a(a)(37)(B) as authority supporting this requirement. See 42 C.F.R. § 447.250. Thus, the effort to find congressional intent to establish a comprehensive review scheme rests on a statutory provision that is entirely inapplicable to the issue before the Court.

Further, while Congress required HCFA to review and approve State Plans under the Boren Amendment, HCFA merely reviews the adequacy of the State's assurances, and under its own stated policies, does not conduct any meaningful in-depth review of a State's payment rates.[10] This process can hardly be described as a comprehensive remedial scheme.[11] Moreover, many lower court decisions demonstrate that HCFA's cursory review of State "assurances" often results in approval of State Plans that manifestly do not satisfy the federal standard.[12]

As indicated, the Medicaid statute contains no requirement concerning provider appeals. While HCFA has

[10] The cursory nature of HCFA's review of State "assurances" has often been documented in lower court decisions. See, e.g., AMISUB (PSL) v. Colorado Dep't of Social Services, 879 F.2d 789, 799 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682); California Hosp. Ass'n v. Schweiker, 559 F. Supp. 110, 116-117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

[11] This review and approval process is nearly identical to that required under the AFDC regulations that were deemed insufficient to preclude a section 1983 action in *Thiboutot*. *Compare* 42 C.F.R. §§ 430.10-430.20 *with* 45 C.F.R. §§ 201.2-201.4.

[12] *E.g.*, California Hospital Ass'n v. Schweiker, 559 F. Supp. at 115-17 & n.1 (6% cap on increases in rates, regardless of inflation); Nebraska Health Care Association v. Dunning, 778 F.2d 1291 (8th Cir. 1986) (HCFA approval of 3.75% inflation factor invalid due to failure of State to include "related information" required under regulations), *cert. denied*, 479 U.S. 1063 (1987); Mary Washington Hospital, Inc. v. Fisher, 635 F. Supp. 891, 904 (E.D. Va. 1985) (assurance that Plan contained adequate appeals system "simply not accurate").

adopted a limited appeals requirement, the HCFA regulation is further evidence that Congress did not require a comprehensive scheme for review of Plan deficiencies. Specifically, HCFA's regulation concerning provider rate disputes requires only that the State provide an appeals or exceptions procedure "that allows individual providers an opportunity to . . . administrative review, *with respect to such issues as the agency determines appropriate*, of payment rates." 42 C.F.R. § 447.253(c) (emphasis supplied). The regulation requires only that States create an administrative process for some types of claims and provide an assurance that such claims may be addressed administratively. Thus, in addition to the statute itself being silent, HCFA has not construed the statute as requiring States to establish a comprehensive appeal procedure for hospitals and nursing homes to contest the legality of a State's reimbursement methodology.

A survey of the Medicaid Plans of the 50 States and the District of Columbia confirms the absence of any intent to require such a comprehensive scheme. The limitations present in almost every State Plan make clear that broad-based challenges to the legality of the State's reimbursement methodology may not be raised in the administrave proceedings, which are designed to permit an individual provider to protest adjustments to its allowable costs and the specific rate set for it by the State agency.[13]

The most common limitations placed on rate-related provider appeals are those which limit review to the correction of errors in accounting or auditing data or procedures, and/or which permit rates to be revised only if changed circumstances since the base year have significantly elevated the individual provider's costs. Sixteen hospital and twelve nursing home appeal procedures are

[13] A detailed narrative description of the administrative appeal procedures of these jurisdictions and citations to those procedures are contained in Appendix A. In Appendix B, we have classified the jurisdictions by certain relevant categories.

explicitly restricted in one or both of these ways.[14] For example, in Illinois, a hospital may appeal its rate only for: (1) errors in calculation; (2) severe cash flow problems resulting from serving a disproportionate share of low income patients; or (3) significant "restructuring" since the base year, resulting in changes in required health or safety standards, adding or deleting beds or services, or making other capital changes causing specified cost increases. App. A-8 - A-9.

Several Plans (8 hospital, 5 nursing home) explicitly prohibit use of the provider appeals procedure for challenges to the legality of the State's methodology for rate determinations.[15] A typical example is Virginia's Plan for long term care, which states that "the principles of reimbursement are not appealable," and limits appeals to "the interpretation and application of those principles." App. A-26.

Another typical limitation (5 hospital, 4 nursing home) that precludes challenges to the legality of the ratesetting methodology is a prohibition on review of one or more key elements of the methodology.[16] In the Virginia Plan at issue, for example, hospitals may not use the appeal procedure to challenge the State's method for determining peer groupings, the initial peer group cost ceilings or the annual inflation adjustment "escalator." J.A. 33; App. A-26. In Virginia, these elements are not only "key"—they represent the *entire* ratesetting methodology.

[14] *Hospital Plans*: Arkansas, Colorado, Florida, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Montana, New Mexico, New York, Tennessee, Washington, Wisconsin. *Nursing Home Plans*: Alabama, Florida, Kansas, Maryland, Nebraska, Nevada, New York, South Carolina, South Dakota, Texas, Vermont, Wisconsin.

[15] *Hospital Plans*: Alabama, Idaho, Michigan, Ohio, Pennsylvania, South Carolina, Texas, Wyoming. *Nursing Home Plans*: Idaho, Michigan, Pennsylvania, Virginia, Wyoming.

[16] *Hospital Plans*: California, Hawaii, Missouri, North Carolina, Rhode Island, Virginia. *Nursing Home Plans*: California, Hawaii, Missouri, North Carolina.

Another group of Plans (2 hospital, 6 nursing home) permit administrative appeals only to determine the conformity of a facility's rate with the "principles governing the determination of rates" set forth in the Plan or regulations. App. A-12.[17] Four other States employ a similar limitation, permitting administrative review only of the "application" or "interpretation" of the principles in the Plan.[18, 19]

Thus, in a significant majority of States, rate appeal procedures for hospitals (33 States) and nursing homes (34 States) clearly preclude providers from contesting the legality of the ratesetting methodology.[20] In most of

[17] *Hospital Plans*: New Jersey, Georgia, *Nursing Home Plans*: Indiana, Maine, Massachusetts, Mississippi, New Jersey, New Mexico.

[18] *Nursing Home Plans*: Colorado, New Hampshire, Kentucky, Rhode Island.

[19] Still other States impose restrictions that, while not expressly precluding review of the rate methodology, nevertheless must have that effect. One State requires that appeal of policy issues be brought within 30 or 35 days of the publication of the policy. App. A-3. Thus providers, who may not realize the negative impact that a particular ratesetting methodology will have until after costs are reported and rates are set for a given year, generally will be precluded from raising challenges to the legality of that methodology. Three other States require that appeals identify particular computations and adjustments, plainly indicating that the procedure is intended to be used for arithmetic, not legal, challenges. *Hospital Plan*: Nevada (appeal must also document adverse financial impact of rate). *Nursing Home Plans*: North Dakota and Utah.

[20] *Hospital Plans*: Alabama, Arkansas, California, Colorado, Florida, Georgia; Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Missouri, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming.

Nursing Home Plans: Alabama, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South

the remaining States, the language of the State Plan or regulations is more ambiguous, but does not suggest that challenges to the ratesetting methodology would be permitted. Most States simply parrot the language of the federal regulation[21] or indicate merely that individual providers are permitted to appeal rates or rate determinations.[22] Absent explicit language to the contrary, there is good reason to assume that the designated administrative decisionmakers, whose role is to resolve individual rate disputes, do not have the authority to invalidate broader policies adopted by the State agency, even if those policies do not comply with federal law.[23]

The number of States whose procedures appear to permit broad-based legal challenges is small indeed. Only eight States have enacted such procedures, and few of these unambiguously grant the right to challenge the legality of ratesetting methodology.[24]

In sum, in addition to the fact that Congress has not mandated that States implement any provider appeal procedure (much less a comprehensive or exclusive one), review of the actual State procedures clearly demonstrates that even HCFA has not interpreted the Medicaid statute to evidence congressional intent to create a com-

Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming.

[21] *Hospital Plans*: District of Columbia, Nebraska, Oklahoma, South Dakota, Utah. *Nursing Home Plans*: Louisiana, West Virginia.

[22] *Hospital Plans*: Iowa, Louisiana, Maine, Oregon, Vermont. *Nursing Home Plans*: District of Columbia, Georgia, Illinois, Montana, Oklahoma, Oregon, Tennessee, Washington.

[23] See, e.g., State Tax Comm'n v. Administrative Hearing Comm'n, 641 S.W.2d 69, 75 (Mo. banc 1982) (administrative agency lacks authority to invalidate properly promulgated regulations: "[a]gency adjudicative power extends only to the ascertainment of facts and the application of existing law thereto").

[24] *Hospital Plans*: Alaska, Arizona, Connecticut, Delaware, Minnesota, West Virginia. *Nursing Home Plans*: Alaska, Arizona, Connecticut, Delaware, Iowa, Minnesota, Ohio.

prehensive remedial scheme that would encompass review of State ratesetting policies. Quite the contrary, HCFA's approval of Plans which typically preclude challenges to the ratesetting methodology further underscores the absence of congressional intent to foreclose access to other remedies.[25]

Nor can HCFA's power to exercise the extreme sanction of terminating federal funding for a noncomplying Plan be regarded as part of a comprehensive review scheme. Although the courts have found that numerous State Plans violate the Boren Amendment, HCFA has never sought to terminate federal funding to a State on this basis. The Medicaid statute's purpose of enabling each State to provide medical assistance to the indigent would hardly be served by ejecting a State from participation. The benevolent goal of furnishing adequate medical care demands that some less extreme sanction, such as a section 1983 suit, be available to challenge a State's noncompliance with the Boren Amendment.

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[25] In the *amicus* brief of the state attorneys general, it is argued that HCFA "expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the [Medicaid] statute contained neither mandate nor authority to provide judicial recourse for dissatisfied providers." Br. of *Amici* State of Connecticut *et al.* This assertion is plainly wrong. In the regulatory preamble cited by the attorneys general, HCFA discussed comments received on "who should adjudicate appeals." 48 Fed. Reg. 56046, 56052 (1983). In response to one commentor's suggestion that HCFA should require States to "provide judicial recourse for providers dissatisfied with State payment rates," the agency correctly noted that the Medicaid statute did not grant HCFA authority to *require* such recourse. *Id.* In fact, the statute does not authorize HCFA to restrict or expand judicial review in any way. HCFA also concluded that the regulations did not restrict the right of providers to pursue State judicial remedies after exhausting the administrative process. *Id.* The agency expressed no view on the availability of a private cause of action under section 1983 or any other provision of federal law. *Id.*

II. RECOGNIZING A SECTION 1983 REMEDY WOULD NOT OPEN THE FLOODGATES TO FEDERAL COURT REVIEW OF INDIVIDUAL RATE DISPUTES, BUT WOULD PROVIDE A MEANINGFUL METHOD OF REMEDYING SYSTEMATIC VIOLATIONS OF THE BOREN AMENDMENT

A. Availability of a section 1983 remedy has not produced a flood of Boren Amendment litigation

Every United States Court of Appeals to rule on the question has held that Medicaid-participating health care providers have a right under section 1983 to sue State officials in federal court for Boren Amendment violations.[26] Despite this free access to the federal courts in the decade since the Boren Amendment was enacted, *amici* have discovered only 48 reported federal cases alleging violations of the Boren Amendment.[27] Slightly fewer than half of the federal cases were based on a section 1983 cause of action.[28] All involved challenges to the legality of the State's ratesetting methodology rather than individual rate disputes.

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[26] West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989); Virginia Hosp. Ass'n v. Baliles, 868 F.2d 653, 658 (4th Cir. 1989), *cert. granted in part*, 110 S. Ct. 49 (1989); Coos Bay Care Center v. Oregon Dep't of Human Resources, 803 F.2d 1060, 1062 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036, *vacated as moot*, 484 U.S. 806 (1987); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1295 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); AMISUB (PSL) v. Colorado Department of Social Services, 879 F.2d 789, 798 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682). *Cf.* Yapalater v. Bates, 494 F. Supp. 1349, 1357-58 (S.D.N.Y. 1980) (finding right of action under prior reimbursement provision), *aff'd per curiam*, 644 F.2d 131 (2d Cir. 1981), *cert. denied*, 455 U.S. 908 (1982); Silver v. Baggiano, 804 F.2d 1211, 1217-18 (11th Cir. 1986) (reserving question).

[27] See Appendix C.

[28] In most of the other cases, the issue of whether a cause of action was available was not considered by the court. *E.g.*, Alabama Hosp. Ass'n v. Beasley, 702 F.2d 955 (11th Cir. 1983).

While there have been a limited number of cases arising under section 1983, in the majority of the cases in which the court reached the issue of the legality of the ratesetting methodology, the court found the need to grant relief to prevent arbitrary or unlawful State action.[29] These cases demonstrate that the existence of a private cause of action permitting providers to challenge the legality of a State's ratesetting methodology has not produced a flood of litigation, and no reason exists to assume that a ruling by this Court upholding this right would increase significantly the number of such challenges.[30] Moreover, the success of many of these challenges is good evidence that this remedy is needed to assure State compliance with the standard contained in the Boren Amendment.

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[29] See AMISUB, 879 F.2d 789; West Virginia Univ. Hosps., 885 F.2d 11; Nebraska Health Care Ass'n, 778 F.2d 1291; Washington State Health Facility Ass'n v. Washington Dep't of Social and Health Services, 698 F.2d 964 (9th Cir. 1982); St. Tammany Parish Hosp. Service Dist. v. Dep't of Health and Human Resources, 677 F. Supp. 455 (E.D. La. 1988); Children's Memorial Hosp. v. Illinois Dep't of Public Aid, 562 F. Supp. 165 (N.D. Ill. 1983); Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid, 576 F. Supp. 360 (N.D. Ill. 1983). Section 1983 has also been successfully used by Medicaid recipients to challenge a State's ratesetting methodology. Montoya v. Johnston, 654 F. Supp. 511 (W.D. Tex. 1987); Thomas v. Johnston, 557 F. Supp. 879 (W.D. Tex. 1983).

[30] Boren Amendment litigation is extremely costly and time consuming, due to the necessity of obtaining detailed expert and accounting reports establishing that the State's methodology will not result in efficiently and economically operated facilities receiving reimbursement approximating their actual costs. This requires analysis not only of an individual facility's costs, but those of all similar facilities in the State. See generally, Hamme & Kanner, Long-Term Care Reimbursement Issues: Pro and Contra Aids for Litigants, in 1989 Health Law Handbook (Clark Boardman Co., A. Gosfield, Ed. 1989). As a practical matter, it is not economically practicable for an individual provider to initiate Boren Amendment litigation simply to challenge its rate.

B. The absence of a remedy would permit State Plans which contain egregious violations of the Boren Amendment to continue in operation

To leave providers without a federal remedy for violations of the Boren Amendment would create the prospect of arbitrary or unlawful State action with no effective remedy and extremely significant consequences for hospital and nursing home providers and, hence, Medicaid recipients. As noted above, implementation of unlawful and inadequate rates will have an adverse impact on the quality of services provided to the vulnerable indigent population who require inpatient hospital or nursing home services covered by Medicaid. That States have implemented ratesetting methodologies which contain egregious violations of the Boren Amendment has often been documented in lower court cases.

Two recent circuit court decisions illustrate this problem graphically. In *AMISUB (PSL) v. Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682), the State implemented a Plan under which a hospital's base year Medicaid rate was determined by taking the average *Medicare* per diem reasonable cost per discharge for hospitals in a particular peer grouping, and multiplying that figure by .88. *Id.* at 791. The resulting figure then was multiplied by a "budget adjustment factor" of .54 to arrive at the *Medicaid* rate for each facility. *Id.*

In effect then, under Colorado's methodology, hospitals would receive a per diem rate for Medicaid patients that was less than half of the average cost that would be deemed reasonable by Medicare for the same patient. Expert testimony at trial established that under this system, no Colorado hospital, no matter how efficiently and economically operated, would be reimbursed its reasonable costs. *Id.* at 798-99.[31] The court concluded that such

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[31] The court noted that while the State's "assurances" of adequate reimbursement might be "adequate for HCFA, . . . at trial a

a large across-the-board reduction, based solely on budgetary considerations, violated the Boren Amendment. *Id.* at 799.[32]

Other ratesetting provisions may be equally violative of the Boren Amendment. In *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989), the court was confronted with provisions in Pennsylvania's Plan, which computed rates for out-of-state hospitals providing care to Pennsylvania's Medicaid recipients differently than for in-state hospitals providing the same services. Rates for in-state hospitals were computed by taking an average cost per hospital stay (based on actual allowable costs) and adjusting that amount for each stay by a factor designed to account for the relative severity (cost) of the case. *Id.* at 16.

In contrast, rates for out-of-state hospitals were computed based not on allowable costs, but on the average of payments made to in-state hospitals (adjusted for severity). *Id.* In addition, out-of-state hospitals received lower reimbursement for capital costs, and no reimbursement for direct medical education expenses. *Id.* The district court found that this situation resulted in the plaintiff hospital receiving only 54 percent of its costs of treatment to Medicaid patients, as opposed to the 95 percent received by in-state hospitals. *Id.* at 25.

The Colorado and Pennsylvania Plans provide compelling examples of the potential for significant harm to hospitals and nursing homes, and ultimately to Medicaid recipients, that can occur where rates are predicated on

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party must offer evidence which supports its position." *Id.* at 799. The court found no such evidence.

[32] A smaller across-the-board reduction in nursing home rates, based solely on budgetary considerations, was invalidated in Nebraska Health Care Ass'n v. Dunning, [1984 Transfer Binder] Medicare & Medicaid Guide (CCH), ¶ 34,100 (D. Neb. July 9, 1984) (reductions of 14.4% for intermediate care facilities and 4.4% for skilled nursing facilities), *aff'd in part and vacated in part on other grounds*, 778 F.2d 1291 (8th Cir. 1985) (State did not appeal invalidation of across-the-board reductions), *cert. denied*, 479 U.S. 1063 (1987).

budgetary or other constraints wholly unrelated to the health care needs of patients.[33] No one, and certainly not Congress in agreeing to provide funding for State Medicaid programs, could seriously expect hospitals and nursing homes to provide adequate care where reimbursement is set at one-half of the costs needed to provide quality services. Consequently, the courts, when confronted with these egregious cases, have appropriately concluded that such Plans fail to meet the statutory standard requiring rates that are adequate to permit efficiently and economically operated facilities to provide quality care.

Congress has repeatedly shown its concern about the need to maintain appropriate Medicaid funding for the poor and disabled, and there is no basis for concluding that Congress intended to insulate from meaningful scrutiny the types of unlawful payment reductions that occur when a State adopts a reimbursement methodology that flatly violates the State's obligations under the Boren Amendment. As this Court noted in *Rosado v. Wyman*, 397 U.S. 397 (1970), it is the duty of the federal courts, "no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use." *Id.* at 422-23. Under the scheme created by Congress, the appropriate mechanism for ensuring compliance with the Boren Amendment is a suit under 42 U.S.C. § 1983 brought by providers.

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[33] Other pending challenges to egregious State Plans of which *amici* are aware of include, *inter alia*, Albert Einstein Medical Center v. White, Civ. No. 88-8831 (E.D. Pa. filed Nov. 17, 1988) (challenge to Pennsylvania 14.6% across-the-board reduction in aggregate group rates); Michigan Hosp. Ass'n v. Department of Social Services, No. L89-40070 CA (W.D. Mich. filed July 25, 1989) (challenge to prospective payments 9% less than actual operating costs and inadequate inflation update factors); Ohio Hosp. Ass'n v. Dep't of Human Services, No. 88-04961, slip op. (Oh. Ct. Claims. Nov. 2, 1988) (challenge to 6% and 8% per fiscal year reductions in outpatient reimbursement), *appeal pending*, No. 88-AP-1034 (Oh. Ct. App.).

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDICES

APPENDIX A

Survey Of Procedures For Rate-Related Appeals By Medicaid Providers In The 50 States And The District Of Columbia

In this Appendix, *amici* describe the rate-related Medicaid provider appeal procedures of the 50 States and the District of Columbia. Data for this survey were collected primarily pursuant to the Freedom of Information Act, 5 U.S.C. § 552 (1982 Supp. 1987), from files of HCFA's central headquarters in Baltimore, Maryland. Under Medicaid regulations, State Plans or amendments thereto are submitted in the first instance to the HCFA regional office with jurisdiction over the particular state. *See generally* 42 C.F.R. §§ 430.10-430.20 (1988). While some matters may be approved at the regional level, central office approval is required for the reimbursement portion of each State Plan. Health Care Financing Administration, Regional Office Manual (HCFA-Pub. 23-6), § 6301. Reimbursement methodology, including the appeals procedures required by 42 C.F.R. § 447.253(c), is contained for hospitals in Attachment 4.19-A, and for nursing homes in Attachment 4.19-D, to each State's Plan. When a Plan is ultimately approved, the State's original materials are returned to the regional office for filing. The central office retains a copy for its files. Because States may implement a new methodology concurrently with seeking HCFA approval, some of the State Plan versions actually in effect may be more current than those obtained from the central office for this survey. However, every Plan reviewed for this survey has been approved by HCFA, and so illustrates the kinds of appellate procedures that the agency deems sufficient to satisfy the requirements of the statute and regulations.

In a few states, the State Plan on file with the central office did not contain a procedure for provider rate appeals. In these states, *amici* AHA and AHCA contacted their State member organizations, or the State Medicaid

agency, to obtain the necessary information. As the citations in this Appendix indicate, appeal procedures in these States may be located in State administrative regulations, or State Medicaid provider manuals.

ALABAMA

Hospital (Attachment 4.19-A, TN AL-88-17). Under the State Plan, providers of hospital services are permitted to appeal actions resulting from the provisions of the Plan. *Id.* at Sec. XIV, p. 11. However, providers are not permitted to use this appeals process to question the use of Medicaid standards and principles of reimbursement; the method of determining the trend factor; the use of all-inclusive prospective reimbursement rates; or the use of hospital group ceilings. *Id.*

Nursing Home (Attachment 4.19-D, TN AL-88-7). The only appeal procedure provided to nursing homes permits a contest of the Alabama Medicaid Agency's factual findings in support of its audit adjustments to the facility's cost report. *Id.* at 6.

ALASKA

Hospital (Attachment 4.19-A). A hospital which is aggrieved by an action of the Medicaid Rate Commission may appeal the decision and request an administrative hearing before a Hearing Officer appointed by the Governor. *Id.* at Sec. VII, pp. 7-8. The Plan specifies that judicial review is available if a facility feels aggrieved following the administrative hearing. *Id.*

Nursing Home (Attachment 4.19-D). The State Plan provides the same procedure as above for nursing homes. *Id.* at Sec. VII, pp. 11-12.

ARIZONA

Arizona does not participate in Medicaid, but rather in a HCFA demonstration project called the Arizona Health Care Cost Containment System ("AHCCCS"). Under this system, the exclusive means through which

providers may grieve against the Administration in connection with any adverse action, decision, or policy is to file a written grievance with the AHCCCS Appeal and Grievance Division within 35 days of the adverse action or decision. Ariz. Comp. Admin. R. & Regs. R9-22-804, p. 239 (5/30/89). No different time provision is indicated for challenges to policy, such as the State's rate-setting methodology, and compliance with the procedures is a prerequisite to judicial review. *Id.* at p. 241.a.

ARKANSAS

Hospital (Attachment 4.19-A, TN 88-26). Providers of hospital services are permitted to appeal their rates only for the folowing reasons: (1) costs of improvements incurred because of new certification or licensing requirements; (2) extraordinary circumstances (fires, floods, etc.); (3) program decisions of a substantive nature relating to application of the payment system; or (4) the rates are substantially below those paid during an earlier base period. *Id.* at Sec. 1.09, p. 15.

Nursing Home (Attachment 4.19-D). The Plan permits nursing homes to submit written appeals of any provisions of the State Medicaid Manual (Plan) or actions resulting therefrom, to the Commissioner of Arkansas Social Services. *Id.* Sec. 1-7. Appeals must be submitted within 30 days of notification of initial publication of a Manual provision, or an adjustment to a cost report. *Id.* No procedure exists for contesting Manual provisions after this time has elapsed.

CALIFORNIA

Hospital (Attachment 4.19-A, TN 87-16). The Plan permits a hospital to request an administrative adjustment to its interim rate. *Id.* at Sec. V, p. 9. However, the Plan specifically excludes consideration of the following:

a. The use of Medicare standards and principles of retrospective reimbursement;

b. The method for determining the input price index;

c. The use of all-inclusive reimbursement rates;

d. The use of a volume adjustment formula;

e. The use of hospital peer groups;

f. The use of percentile limits and the methods used to compute them.

An appeal of the Department's decision may be filed in accordance with the procedural requirements of Cal. Admin. Code, tit. 22, Div. 3, Ch. 3, Art. 1.5. *Id.* at 11. The appeal is limited to those items subject to an administrative adjustment listed above. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-24). The Plan states that nursing homes will have the right to appeal audit findings which result in adjustments to program reimbursement or reimbursement rates. *Id.* at 4. However, the Plan specifically limits reimbursement rates to maximums set by the Plan itself, "[n]otwithstanding any other provisions" of the Plan. *Id.* at 1.

COLORADO

Hospital (Attachment 4.19-A). The Plan permits hospitals to appeal administratively only annual "add-ons" to the established base year rate. *Id.* at 1. Add-ons are increases in budgeted costs in excess of the consumer price index that can be justified on the basis of or resulting from a new or expanded service, a price increase, or a change in patient case mix. *Id.* Regulations applicable to all Medicaid providers limit appeals to a provider "adversely affected by a finding of fact or interpretation of rules. . . which results in a reduction in, or denial of, specific payments." 11 Colo. Code Regs. Sec. 8.0501 (effective 5/1/86).

Nursing Home (Attachment 4.19-D, TN 89-4). The Plan assures that Colorado has established procedures for nursing home rate determinations which permit pro-

viders to submit additional evidence and request prompt administrative review. *Id.* at 30. The regulations cited above for hospitals also apply.

CONNECTICUT

Hospital (Conn. Gen. Stat. § 17-311 (1989)). Connecticut hospitals may appeal any decision of the Commissioner of Income Maintenance in accordance with the aforementioned statute, which empowers the Commissioner to establish annual allowable costs for Medicaid Services. *Id.* An "aggrieved" hospital may request a rehearing as to any decision of the Commissioner. *Id.* at § 17-311(b). Items not resolved through the rehearing are submitted to an arbitration board consisting of one member appointed by the institution, one member appointed by the Commissioner, and one appointed by the chief court administrator. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-58). A nursing home aggrieved by any decision of the Commissioner of Income Maintenance may file a written request to the Commissioner requesting a rehearing on the items of aggrievement. *Id.* at Sec. 17-311-104. If items of aggrievement are not resolved by the rehearing, the provider can file a request for binding arbitration, which must include a memorandum setting forth its position and contentions concerning the items of aggrievement. *Id.* at Sec. 17-311-107. The arbitration board consists of one member appointed by the provider, one member appointed by the Commissioner, and one member appointed by the chief court administrator from among the retired judges. *Id.* The Board may reverse the department if administrative findings, inferences, conclusions, or decisions are, among other things, violative of constitutional or statutory provisions. *Id.* at Sec. 17-311-112.

In contesting a rate decision, the provider may elect to pursue an administrative appeal in the Connecticut Superior Court in lieu of arbitration. *Id.* at Sec. 17-311-120.

DELAWARE

HCFA's copy of the State Plan contains no provision for provider rate appeal by hospitals or nursing homes. Appeals of "adverse actions" by the State Medicaid agency are permitted pursuant to State Medicaid regulations. Department of Social Services, Appeal Procedures of Adverse Actions for Providers (4/89). Requests for review must be mailed within 60 days of notice of adverse action. *Id.* at Sec. 5.

DISTRICT OF COLUMBIA

Hospital (Attachment 4.19-A, TN 88-6). The State Plan provides only an assurance of the existence of an appeal procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of rates. *Id.* at Sec. 9, p. 4a. In a telephone conversation with the Comptroller's office, we were informed that, although there are no formal appeal procedures, hospitals are permitted to appeal informally adjustments to annual cost reports.

Nursing Home (Attachment 4.19-D). The Plan permits a nursing home to request a hearing before the Office of State Agency Affairs if the provider disagrees with a rate established by a Department of Human Services audit. *Id.* at Sec. VII.

FLORIDA

Hospital (Attachment 4.19-A, TN 88-19). The Plan permits a hospital the right to a hearing in response to adjustments to its cost report resulting from an audit. *Id.* at Sec. II (F), p. 8. The right to the hearing will be in accordance with Fla. Admin. Code Ann. r. 10-2.36, and with the Florida Administrative Procedure Act, Fla. Stat. Ann., Sec. 120.57.

Nursing Home (Attachment 4.19-D, TN 88-3). The same right to a hearing is available to nursing home providers in accordance with Fla. Admin. Code Ann. r. 10C-7.481(6), and with Fla. Stat. Ann., Sec. 120.57.

GEORGIA

Hospital (Attachment 4.19-A, TN 85-22). The State Plan provides a procedure whereby the hospital must submit a written request for review to the State Director of Hospital Reimbursement, with further appeal to the Director of Program Management. *Id.* at 10. If that decision is adverse to the hospital, a request for a hearing may be made in accordance with Chapter 500 of the Department's Policies and Procedures Manual. *Id.* at 12. This procedure may be used to consider only: (1) errors in cost report figures used to determine the base rate; (2) errors in calculation; (3) failure of the Department to comply with its stated policies; or (4) increased costs due to significant changes in patient care services. *Id.* at 10. *See also* Georgia Department of Medical Assistance Medicaid Manual, Chapter 500, Sec. 505.2.

Nursing Home (Georgia Department of Medical Assistance Medicaid Manual, Chapter 500). Georgia permits nursing homes to appeal the calculation of billing rates and related cost report disallowances. *Id.* at Sec. 504.3.

HAWAII

Hospital (Attachment 4.19-A, TN 88-30). The Plan permits a hospital to request reconsideration by the Department of its annual rate only "in extraordinary circumstances", or when there is a "[r]eduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day." *Id.* at III-36. "Extraordinary circumstances" include acts of God, changes in life and safety code or licensure requirements, significant changes in case mix or new services occurring subsequent to the base year. *Id.* In addition, subsequent year adjustments to the facility's initial base year rate may not result in changes to the Plan's rate ceiling. *Id.* at III-35.

Nursing Home (Attachment 4.19-D, TN 86-17). The Plan permits nursing homes the right to request a rate

reconsideration only for additional capital costs, change in level of care provided,. or "extraordinary circumstances," such as Acts of God, changes in life safety code requirements, or significant changes in patient mix. *Id.* at 11. Reconsideration may be appealed, but rates granted may not exceed the sum of component rate ceilings for the applicable facility classification specified in the Plan. *Id.* at 12.

IDAHO

Hospital (Attachment 4.19-A). The Plan permits hospitals to file grievances or complaints with the Bureau of Medical Assistance. *Id.* at 03.10500, p. 10. Adverse decisions may be appealed through the State Administrative Procedure Act, and judicial review is available. *Id.* The administrative appeal procedure is not available to contest, *inter alia*, the formula for determination of the Hospital Cost Index, or the principles of reimbursement which define allowable cost. *Id.* at 03.10463, p. 9.

Nursing Home (Attachment 4.19-D, TN 87-7). The Plan permits a nursing home to challenge an action or determination of the Department of Health and Welfare. *Id.* at Sec. 03.10305. The administrative process may be used only to adjust rates to correct inequitable application of a rule due to unforeseen cost increases (or decreases) not compensated for by the rule's inflation indices, which were outside the control of the provider. *Id.* at Sec. 03.10303. Challenges to the legal validity of a rule are excluded from the administrative process. *Id.* at Sec. 03.10304.02.

ILLINOIS

Hospital (Attachment 4.19-A, TN 82-9). The Plan permits a hospital to request review by the Department of Public Aid of its annual rate only for errors in calculation, severe cash flow problems (resulting from serving a disproportionate share of low income patients), or significant restructuring (to meet new health and safety

standards, to add or delete beds or a service category, or to make other capital changes resulting in stated cost increases). *Id.* at 4a-4c.

Nursing Home (Attachment 4.19-D, TN 86-44). The Plan provides for nursing homes to appeal, in writing, rate determinations. *Id.* at 35. If the appeal is submitted within 30 days of notification, it will (if upheld) be effective as of the beginning of the rate year. Later submitted appeals, if upheld, are effective the first day of the month following submission.

INDIANA

Hospital (Ind. Admin. Code tit. 470). Indiana regulations permit a hospital to provide additional information to the Department of Public Welfare should it disagree with its calculated rate. *Id.* at r. 5-11-1(f). The additional information must be based on actual financial data. *Id.* The Department will affirm or adjust the rate based on review of the additional information. *Id.* Further administrative and judicial review also are permitted. *Id.* at r. 5-4.1-27.

Nursing Home (Attachment 4.19-D, TN 83-5). The Plan permits a nursing home to request reconsideration of a rate determination, or any procedures in connection therewith, to the Medicaid Rate Setting Contractor. *Id.* at Sec. 27, p. 52. If the provider is dissatisfied with the decision of the Contractor, or other actions taken by the Department, an appeal is filed with the Department. *Id.* at 53. Further reviews are available before a hearing officer, the Board of Public Welfare, and finally in State court. *Id.* at 53-55. The Plan provides for correction on appeal only if the rate established by the Contractor's action was not in accordance with the ratesetting criteria in the Plan. *Id.* at 53.

IOWA

Hospital (Attachment 4.19-A, TN MS-87-27). The plan permits a hospital provider to file a written appeal

with the Department of Human Services if dissatisfied with a rate determination. *Id.* at Sec. 20, p. 12. Hearings are conducted by the Department of Inspections and Appeals. *Id.* The Department of Human Services makes a decision based on the recommendation of the Department of Inspections and Appeals. *Id.*

Nursing Home (Attachment 4.19-D). If dissatisfied with the determination of its base year allowable cost, a nursing home may file an appeal and request for reconsideration with the Chief of the Bureau of Medical Services. *Id.* at Sec. 11, p. 3. In addition, Iowa regulations permit the Department to consolidate the claims of several providers where the sole issue involved is one of state or federal law or policy. Iowa Admin. Code. r. 441-7.5 (1987).

KANSAS

Hospital (Attachment 4.19-A, TN MS 88-27). A hospital may obtain administrative review only upon evidence of at least a 10% variation between its current Medicaid cost and its per diem rate. *Id.* at Sec. N, p. 7. The Commissioner of Income Maintenance shall render a decision which is appealable under Kan. Admin. Regs., Sec. 30-7. *Id.* There is no provision to contest rates (or rate methodology, if permitted) unless the 10% criterion is met.

Nursing Home (Attachment 4.19-D, TN MS-89-15). The Plan for nursing homes provides a procedure for individual providers to obtain an "exception" to their assigned rates by submitting additional evidence demonstrating that the provider is efficiently and economically operated, but is being adversely affected by the Plan payment rates. *Id.* at p. 20A.

KENTUCKY

Hospital (Attachment 4.19-A, TN 86-4). A hospital may appeal a program decision only in the following circumstances: (1) addition of new and necessary services

requiring certificate of need approval; (2) major changes in case mix or types/intensity of services; (3) costs of improvements required by new licensing or certification requirements; (4) extraordinary circumstances (floods, etc.); substantive program decisions relating to application of the payment system. *Id.* at Sec. 110, p. 110.01.

Nursing Home (Kentucky Medical Assistance Program Reimbursement Manual, TN 84-16). Nursing homes are permitted administrative review of program decisions relating to the application of the policies and procedures governing the nursing home payment system. *Id.* at Sec. 119, p. 119-01.

LOUISIANA

Hospital (Attachment 4.19-A, TN 84-9). The Plan provides that hospitals may appeal their rates to the DHHR Appeals section. *Id.* at Sec. III, p. 11. An informal conference is first scheduled between the hospital and the state agency to discuss the issues of the appeal. *Id.* If the informal discussion does not resolve these issues, the hospital may request an administrative hearing with the DHHR Appeals Section. *Id.* at p. 12. The DHHR Appeals Section makes a recommendation to the Secretary. The department then makes a final decision, subject only to judicial review by the courts as provided in the State Administrative Procedure Act, La. Rev. Stat. Ann., Sec. 49:951. *Id.* at 13.

Nursing Home (Attachment 4.19-D (1)). The Plan for nursing homes assures that the State provides an appeals procedure that permits individual providers to submit additional evidence and receive prompt administrative review. *Id.* at p. 4. In a telephone conversation with the Department of Health and Human Resources, however, we were informed that a provider could *not* appeal a rate determination.

MAINE

Hospital (Attachment 4.19-A, TN 88-07). The Plan assures that a provider appeals system is in place which allows individual providers an opportunity to submit ad-

ditional evidence and request prompt administrative review of payment rates. *Id.* at 2.

Nursing Home (Attachment 4.19-D, TN 88-14). Nursing homes may appeal audit adjustments to the Maine Department of Human Services. On appeal, the validity of a rate is judged "solely on the basis of its conformity with the principles governing the determination of rates contained in this attachment [4.19-D]." *Id.* at 18.

MARYLAND

Hospital (Md. Regs. Code tit. 10, Sec. 37.10 (1988)). A hospital may request a temporary change in rates at any time if it has experienced a decline in net revenue or an increase in expenses due to factors beyond its control. *Id.* at Sec. 10.37.10.05.

Maryland also permits a hospital to file an application with the Health Services Cost Review Commission to request an alternative method for submitting or reviewing its rates and charges. 10.37.10.06(A). The Executive Director may grant a temporary approval of an alternative method of rate determination. 10.37.10.06 (B).

Nursing Home (Medical Care Programs ICF Services). Maryland permits nursing homes to appeal only audit findings. *Id.* at pp. 608-45.

MASSACHUSETTS

Hospital (Attachment 4.19-A(2), TN 88-12). HCFA retains two Massachusetts hospital plans, one for acute care facilities, one for non-acute facilities.

The Plan does not contain an appeal procedure for acute care hospitals. In a telephone conversation with the State Rate Setting Commission, we were informed that acute care hospitals may appeal Medicaid reimbursement rates in accordance with State regulations. Mass. Regs. Code tit. 801, Sec. 1.03 (1986). Appeals from actions or inactions on the part of the Rate Setting Commission are permitted for the appeal of interim and final rates. *Id.* at Sec. 1.03(12)(c), (d).

The Plan for nonacute hospitals provides for appeal to the Division of Administrative Law Appeals, pursuant to the requirements of Mass. Gen. L. Ch. 6A, Sec. 36 and Mass. Gen. L. Ch. 7, Sec. 4H, in two circumstances. First, a hospital may request an increase in its allowed costs due to costs beyond its control. *Id.* at 10. Such requests will be granted only if the additional costs: (1) are due to correcting deficiencies related to hospital licensure or participation in Medicare or Medicaid; (2) are generated by compliance with new, non-discretionary regulations mandating expenses; (3) result from disaster losses in excess of (or not covered by) insurance; (4) are allowed in connection with a major capital expenditure or substantial change in services requiring a certificate of need; (5) result from a new service; (6) result from certain wage adjustments which are demonstrated to be cost-effective; (7) result from an increase in patient care costs due to serving a more intensely ill patient population. *Id.* at 10-11. Second, a hospital may request an adjustment if there has been an arithmetic error. *Id.* at 20.

Nursing Home (Mass. Regs. Code tit. 114.2, Sec. 2.20 (1987)). Massachusetts reimburses certain nursing homes through interim rates with retrospective adjustments, and certain nursing homes through prospective rates. This regulation permits both kinds of providers to petition for an increase to their rates. *Id.* at Sec. 2.20, 2.21, 5.15. Petitions for increase in interim rates are granted only for facilities with a population of more than 75 percent Medicaid patients, and only to implement certain statutory wage increases for nurses and nurse aides. *Id.* at Sec. 2.20, 2.21. As to prospective rates, a provider aggrieved by a rate of payment may file an appeal, the validity of which will be "judged solely on the basis of its conformity with the principles governing the determi-

nation of rates contained in" the ratesetting methodology set in the regulations. *Id.* at Sec. 5.16(1) and (2).

MICHIGAN

Hospital (Attachment 4.19-A, TN 88-6). The Plan permits a hospital to appeal its rate of payment as well as the components used to determine the rate. *Id.* at Sec. IV, p. 18. Appeal is restricted to the extent that incorrect data were used in calculation, except that the appeal panel or ALJ may also hear appeals of "other items deemed . . . to be within the scope of their jurisdiction." *Id.* An order from the Director of the Department of Social Services states that ALJs do not have "authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations or overrule or make exceptions to the Department policy set out in the program manuals." Amended Delegation of Hearing Authority (April 1, 1981). ALJs are permitted to make a recommendation to the Director of the Bureau of Administrative Hearings when they believe Department policy to be out of conformity with case law, statute, or promulgated regulation, but there is no provision to permit a party to appeal an ALJ's decision on this issue. *Id.*

Nursing Home (Attachment, 4.19-D, TN 87-9). The Plan provides for an informal or formal review of an adverse action, which requires a nursing home to submit an application for relief to the state agency within 45 days of notification. *Id.* at Sec. VIII, p. 1. However, no administrative review is permitted for elements of the program that would necessitate a change for all providers, including the "principles of reimbursement and guidelines which define allowable costs." *Id.* The same Delegation of Authority cited above for hospitals also applies.

MINNESOTA

Hospital (Attachment 4.19-A, TN 88-69). "Rate Appeals" are taken in the first instance to the reimburse-

ment staff of the Department of Human Resources. *Id.* at 9. Appeals that are not settled by reimbursement staff are made to a five member appeals board, appointed by the Commissioner of Human Resources, which makes recommendations to the Commissioner. *Id.* Hospitals may appeal "a decision of the Commissioner" through Minnesota statutes (presumably the Administrative Procedure Act). *Id.*

Nursing Home (Attachment 4.19-D; Minn. R. 256B.50). A nursing home may appeal from determination of a payment rate. *Id.* at Subd.1c, p. 5501. Nursing homes may challenge the validity of the Commissioner's rules in the court of appeals if it appears that the rule or its threatened application impairs or threatens to impair the petitioner's legal rights. Minn. Stat. Ann., Sec. 14.44.

MISSISSIPPI

Hospital (Attachment 4.19-A, TN 81-1). The Plan permits a hospital to appeal its rate to the Mississippi Medicaid Commission. *Id.* at Sec. IV, p. 8. Appeals are limited to new costs resulting from major changes in case mix, the addition of new and necessary services, use of incorrect data or calculation error, extraordinary circumstances (riot, strike, flood, etc.). *Id.*

Nursing Home (Attachment 4.19-D, TN 88-1). The plan permits a nursing home to submit a written request for a formal hearing in response to a rate notice. *Id.* at 19. The appeal must be accompanied by a statement and documents setting forth the facts which the provider contends place it in compliance with the Commission's regulations. *Id.* In addition, the Mississippi Medicaid Manual states that appeals of matters relating to payment rates or reimbursement may be considered only if not otherwise previously considered by the Division of

Medicaid under Public Hearing Procedures. Long Term Care Manual (July 1, 1989) at p. I-7.

MISSOURI

Hospital (Attachment 4.19-A, TN 88-3/87-01). The Plan permits a hospital to request an informal review of actions resulting from the provisions of the Plan. *Id.* at Sec. V(E), p. 10. Items which will not be subject to review include: the use of Medicare standards and reimbursement principles; the method for determining the trend factor; the use of all-inclusive prospective reimbursement rates; and increased cost resulting from change of ownership. *Id.* at 12. In addition, the Missouri Supreme Court has held that State administrative agencies have no authority to render declaratory rulings regarding the validity of agency rules. *State Tax Commission v. Administrative Hearing Commission*, 641 S.W. 2d 69, 75 (Mo. banc 1982). *See* Mo. Code Regs. tit. 13, Sec. 70-10.010 (8/89) (ratesetting methodology as agency rule).

Nursing Home (Attachment 4.19-D, TN 88-22). The Plan permits a nursing home to obtain reconsideration of its rate by an advisory committee only for costs related to changes in the facility's case mix, or costs resulting from other extraordinary circumstances. *Id.* at 51. The Plan prohibits administrative review of the trend factor, the use of prospective rates, or the provider's initial cost base. *Id.* The hospital limitation cited above also applies.

MONTANA

Hospital (Mont. Admin. Rules, Sec. 46.12.506-.510). Hospitals have the opportunity for a fair hearing, in accordance with the procedures set forth in Mont. Admin. R. 46.2.202, only to contest the computation of their interim payment rates (or final settlements for capital and medical education costs), coding errors resulting in incorrect DRG assignment and determination of medical

necessity, outlier status, and readmission/transfer decisions. *Id.* at R. 46.12.510.

Nursing Home (Attachment 4.19-D, TN 88(10)19). A nursing home may request an administrative review of the Department of Social and Rehabilitative Services' written findings, recommendations, or rate. *Id.* at Sec. 46.12.1210, p. 23. If the decision of the review is adverse to the provider, an appeal for a fair hearing can be made to the Department. *Id.* The hearing officer will render a proposed decision, and the provider is permitted a further appeal by filing a notice of appeal with the hearing officer to be forwarded to the Department Director. *Id.* at 23. Judicial review of the decision of the Department Director is permitted under the State Administrative Procedure Act, Title 2, chapter 4, part 7, Mont. Code Ann. *Id.*

NEBRASKA

Hospital (Attachment 4.19-A, TN MS-89-6). The Plan assures that a hospital may submit additional evidence and request prompt administrative review of its prospective rate. *Id.* at 8a. The hospital is also permitted to utilize this procedure to appeal an adjustment to its rate.

Nursing Home (Attachment 4.19-D, TN MS-84-3). The Plan permits a nursing home to request an administrative appeal of a final decision or inaction in the process for determining the facility's allowable cost. *Id.* at Sec. 12-011.13, p. 26.

NEVADA

Hospital (Nevada State Welfare Division, Medicaid Services Manual, MTL 8/89). A hospital is permitted to appeal its rate. *Id.* at Sec. 206.2. The appeal must include the specific rate adjustment requested with supporting documentation and documentation of adverse financial impact. *Id.* In a telephone conversation with the

Welfare Division of the Department of Human Resources, we were informed that this procedure may not be used to appeal the ratesetting methodology.

Nursing Home (Nevada SNF & ICF Medicaid Manual). Nevada permits providers to appeal audit adjustment settlements. *Id.* at Sec. 506.2.

NEW HAMPSHIRE

Hospital. The Plan contains no provision for appeals by hospitals. In a telephone conversation with the State Medicaid Director, we were informed that because hospitals are reimbursed on a diagnosis-related group ("DRG") basis, there are no appeal procedures in place.

Nursing Home (Attachment 4.19-D, TN 87-10). The Plan provides a procedure for individual nursing homes to appeal unresolved disputes that may arise concerning application of the principles of reimbursement defined in the Plan. *Id.* at Sec. 9999.11, p. 38.

NEW JERSEY

Hospital (1983 Standard Hospital Accounting and Rate Evaluation Rate Review Guidelines). Hospitals may file appeals of their payment rates with Health Economics Services, Department of the Public Advocate. *Id.* at G-17. The purpose of the appeal is "to determine if the Guidelines were properly interpreted and executed." *Id.* at G-3. The Plan also provides a provision which permits hospitals faced with unpredictable and uncontrollable changes in costs to submit a request for adjustment to the Commissioner. *Id.* at G-18.

Nursing Home (Attachment 4.19-D, TN 86-1). The Plan provides a two level appeal process for nursing homes that believe that, "owing to an unusual situation, the application of these guidelines results in an inequity." *Id.* at Sec. 3.20, p. C-36. A Level I appeal is heard by representatives from the Department of Health ("DOH") and the Department of Human Services ("DHS"). The

recommended solution will ultimately be forwarded to the Director, Division of Medical Assistance and Health Services for approval. This level is limited to matters peculiar to individual providers.

If the provider is not satisfied with the results of the level I appeal, it may request a hearing before an Administrative Law Judge (Level II). At Level II, the burden is on the provider to establish its entitlement to benefits under the State's Cost Accounting and Rate Evaluation System Guidelines (the State's ratesetting methodology). *Id.* at C-38.

NEW MEXICO

Hospital (Attachment 4.19-A, TN 89-01). A hospital may appeal its rate and its application only if circumstances beyond the hospital's control have caused rates to fall at least 5% below actual allowable costs. *Id.* at Sec. II, p. 2.

Nursing Home (Attachment 4.19-D, Part 1, TN 88-6). The Plan permits a nursing home to file a request for reconsideration of the base year rate determination (or final settlement in the case of a change in ownership). *Id.* at Sec. IX, p. 17. The Medical Assistance Division Director delivers the request and his response to the Secretary of the Department of Human Services, who is empowered (but not required) to hold a hearing. The Secretary's final determination "shall be made in accordance with applicable provisions of the Plan." *Id.* at 18.

NEW YORK

Hospital (Attachment 4.19-A(I), TN 85-34). The appeal procedure provided in the State Plan permits a hospital to appeal audit adjustments to its cost report, as to those items of the audit report that present a factual issue. *Id.* at 10. Pursuant to State Medicaid regulations, the State Commissioner of Health may consider rate revisions only for the following reasons:

(1) mathematical or clerical errors in the rate calculation process, or in the development of [peer] groups;

(2) mathematical or clerical errors in data submitted by the facility;

(3) increases in the operating costs of a facility resulting from additional or expanded programs, staff or services mandated for the facility by the Commissioner;

(4) increases in the operating expenses of a facility resulting from capital renovations, expansion, replacement or inclusion of programs, staff or services approved by the Commissioner through a certificate of need process;

(5) requests for relief for intensity appeals, atypical costs, length of stay penalties, specialty hospital and physicians' base to base noncomparability of cost data, nonprojectable capital, waiver of unfunded depreciation, return on investments of proprietary hospitals, and adjustment in target volume;

(6) the reduction of costs related to the elimination of hospital inpatient service;

(7) requests for relief from the ceiling provisions

(8) requests for waivers of minimum utilization standards; and

(9) requests for reimbursement of costs which were not included in the base year upon which the rate was established.

N.Y. Comp. Code R. Regs. tit. 10, Sec. 86-1.17(a)(1)-(9). The decision of the Commissioner is final unless a hearing is requested with a rate review officer. *Id.* at Sec. 86-1.17(b). The rate review officer may grant or deny the request for a hearing. *Id.* at Sec. 86-1.17(c)(2). The rate review officer shall make a recommendation to the Commissioner of Health for final approval or disapproval. *Id.* at Sec. 86.1-17(c)(3).

Nursing Home (Attachment 4.19-D, Part I, TN 86-4). The Plan permits a nursing home to appeal rate determinations only for increased costs resulting from utilization above 90 percent of bed capacity for a period of six months, errors in the cost and/or statistical data, significant new required or approved cost increases, or other changed circumstances. *Id.* at Sec. 86-2.14, p. 53.

NORTH CAROLINA

Hospital (Attachment 4.19-A, TN 88-17). Hospitals may request reconsideration of rate determinations by the Division of Medical Assistance. *Id.* at 2. Operating (as opposed to capital) rate appeals are considered only on the basis of additional cost of essential new services or changes in case mix, and even an adjusted rate cannot exceed the rate limits set by the Plan itself. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-15). The Plan permits a nursing home to appeal rate determinations in accordance with the procedures set forth in N.C. Admin. Code Tit. 10, r. 26J.0200. (now r. 26K.000). *Id.* at .0106, p. 15. A rate may be adjusted on appeal only if the provider can demonstrate that an adjustment is necessary to protect the health and safety of its patients and to sustain its financial viability. *Id.* The adjusted rate may not exceed the maximum rate established in the Plan itself. *Id.*

NORTH DAKOTA

Hospital (Attachment 4.19-A, TN 87-13). The Plan merely assures that appeal procedures for hospital providers are in place and remain unchanged. In a telephone conversation with the State Medical Services Division, we were informed that there are no formal procedures in place for hospitals to appeal rate determinations.

Nursing Home (Attachment 4.19-D, TN 87-10). The Plan provides that a nursing home may appeal a rate determination to the Referee Supervisor, Department of Human Services. *Id.* at Sec. 75-02-06-17. Appeals are limited to those including a computation and the dollar amount which reflects the party's claim as to the correct computation and dollar amount for each disputed item. *Id.*

OHIO

Hospital (Attachment 4.19-A, TN 87-13). The Plan specifically excludes from the appeals process review of the methodology used to determine rates. Ohio Admin. Code, Sec. 5101:3-2-0712(E), p. 11.

Nursing Home (Attachment 4.19-D, TN 80-16). The appeal procedures in the Plan permit nursing homes an opportunity for a hearing under Chapter 119 of the Revised Code (Administrative Procedures Act) to contest a final fiscal audit. Ohio Admin. Code, Sec. 5101:3-1-57. Administrative action not subject to hearings under Chapter 119 may be reconsidered by the appropriate division chief upon written request by the provider to the Director of the Ohio Department of Public Welfare. *Id.*

OKLAHOMA

Hospital (Attachment 4:19-A, TN 86-17). The Plan provides an assurance that providers of hospital services may submit a request for rate review to the Director of the Department of Human Services for consideration and a final decision. *Id.* at p. 2. The Plan also indicates that providers are allowed an opportunity to submit additional evidence and a prompt administrative review regarding the appropriateness of the payment rate will be conducted. *Id.*

Nursing Home (Medical Services Provider Manual). Oklahoma permits nursing homes to request review of nursing home payment rates to the Director of the Department of Human Services. *Id.* at Ch. 1, p. 12. The

State also provides that facilities are allowed to submit additional evidence and receive prompt review of the appropriateness of the rate. *Id.*

OREGON

Hospital (Attachment 4.19-A, TN 88-17). Under the Plan, hospitals may request an appeal or exception to any State decision affecting payment rates pursuant to Or. Admin. R. 461-13-191 through 461-13-225. *Id.* at 13. These regulations, which apply to hospitals and nursing homes, limit reconsiderations to: (1) individual institutional provider payment ratesetting; (2) issues related to prepaid capitated contracts; or (3) any other issues deemed appropriate by the ageney. Or. Admin. R. 461-13-191(2). As the only specific provision relating to ratesetting, the first clause should preclude the more general language of the third clause from authorizing broad-based appeals.

Nursing Home (Attachment 4.19-D, Part 1, TN 87-34). The Plan states that a nursing home may appeal interim rates or year end settlements to the Senior Services Division. *Id.* at Sec. VI, p. 6. The hospital regulations described above also apply.

PENNSYLVANIA

The State Plan contains no provision for appeals by hospitals or nursing homes. Pennsylvania's administrative regulations furnish providers a fair hearing process for certain medical assistance decisions. 55 Pa. Code § 275.1(a), p. 275-1 (May, 1989). The regulations specifically preclude administrative hearing officers from rendering a decision on the validity of a Departmental regulation, and from invalidating or modifying a regulation. *Id.* at Sec. 275.4(h), p. 275-21.

RHODE ISLAND

Hospital (Attachment 4.19-A). The Plan provides a statewide "maxicap" on hospital operating expenses. *Id.*

at 31. This amount is negotiated annually by representatives of the State and participating hospitals prior to commencement of the new rate year. While individual hospital budgets may be adjusted (through mediation or arbitration between a provider and the State), *see id.* at 46-50, the aggregate total of all hospital expenses in the state may not exceed this ceiling. *Id.* at 31.

Nursing Home (Principles of Reimbursement for Skilled Nursing and Intermediate Care facilities, TN 88-01). The Plan permits a nursing home to request a review of computation of the facility's assigned rate if the provider is not in agreement with the base year or with application of the State's Principles of Reimbursement for the applicable calendar years. *Id.* at 16.

SOUTH CAROLINA

Hospital (Attachment 4.19-A, TN 87-10). Hospitals may have their rates reconsidered only if one of the following has occurred since the base year: (1) change in case mix; (2) error in calculation; (3) extraordinary circumstances. *Id.* at 25-26. The Plan specifically prohibits reconsideration (appeal) of the State's rate methodology. *Id.* at 26.

Nursing Home (Attachment 4.19-D, TN 87-14). The Plan permits nursing homes to appeal only a final audit determination in connection with a desk review of the provider's cost report. *Id.* at 8.

SOUTH DAKOTA

Hospital (Attachment 4.19-A, TN 88-12). The Plan assures that the State Department of Social Services has administrative review procedures to meet the need for provider appeals required by 42 C.F.R. § 447.258 [sic.]. *Id.* at 4.

Nursing Home (S.D. Admin. R. 67:16:04:07.02 (1989)). South Dakota regulations permit a facility to

appeal only a disallowed expenditure or adjustment based on a Department audit of its cost report. *Id.*

TENNESSEE

Hospital (Attachment 4.19-A, TN 88-15). The Plan lacks a specific appeal procedure, but adjustments to a facility's rate are permitted only for errors in computation, additional capital expenditures pursuant to a certificate of need, or significant changes in case mix. *Id.* at p. 10.

Nursing Home. Tennessee's State Plan contains no provision for rate appeals by nursing home providers. The State has no published procedures, but permits appeal of specific rates informally through the Comptroller of the Treasury, and formally through the State Administrative Procedures Act.

TEXAS

Hospital (Attachment 4.19-A, TN 89-20). Hospitals are permitted to appeal individual claims (as specified in the State Plan), mechanical, mathematical, and data entry error in base year claims data, and incorrectly computed subsequent adjustments to the hospital's base year claims data. *Id.* at 5-7. The Plan expressly precludes appeal of the prospective payment methodology used by the State. *Id.* at 7.

Nursing Home (Attachment 4.19-D, 85-2). The Plan assures that an appeals procedure for nursing home providers is available to contest any cost report disallowance. *Id.* at 2.

UTAH

Hospital (Attachment 4.19-A, TN 89-11). The Plan assures that the State has administrative review procedures to handle provider appeals as required by 42 C.F.R. § 447.253(c). *Id.* at Sec. 193.

Nursing Home (Attachment 4.19-D, TN 88-28). The Plan states that a nursing home may appeal an audit

settlement or a revised payment rate. *Id.* at Sec. 920, p. 14. An appeal must identify a specific audit adjustment or rate calculation. *Id.* The purpose of the appeal procedure is to allow individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates. *Id.* at 930.

VERMONT

Hospital (Attachment 4.19-A). The Plan merely assures that appeals of the rates set are allowed.

Nursing Home (Attachment 4.19-D, TN 88-11). The Plan permits a nursing home to submit an appeal to the Division of Rate Setting. Appeals are limited to errors in the calculation of prospective rates. *Id.* Sec. 209. A party aggrieved by a final order of the Division has the option of appeal to the Vermont Supreme Court, trial *de novo* in superior court, or a hearing conducted by an accountant appointed by the Secretary of Human Services. Vt. Stat. Ann. tit. 33, Sec. 195.

VIRGINIA

Hospital (Attachment 4.19-A). The Plan specifically prohibits appeal of the use of Medicaid principles of reimbursement to determine reimbursement of costs (other than operating costs for inpatient care), the calculation of the initial group ceilings on allowable operating costs for inpatient care, and the use of the Consumer Price Index as a prospective rate escalator. J.A. 33.

Nursing Home (Attachment 4.19-D, TN 86-11). Nursing homes may appeal the interpretation and application of the Plan's principles of reimbursement. *Id.* at Sec. 3.3, p. 33. The Plan specifically prohibits appeal of the principles of reimbursement themselves. *Id.* at Sec. 3.1, p. 32.

WASHINGTON

Hospital (Division of Medical Assistance, Inpatient Hospital Rate Appeal, effective April 1, 1986). Washington permits hospitals to appeal their rates by submitting a written notice, including a statement of the issue being appealed and the requested re-calculation of the rate. *Id.* at 1. The procedure allows appeals of computation errors, errors in cost report data, or changes in case-mix or cost apportionment. *Id.*

Nursing Home (Attachment 4.19-D, TN 87-18). The Plan permits a nursing home to request a revision of its rate at any time. *Id.* at Sec. IV, p. 5. The provider may appeal first through an administrative review conference. *Id.* If the decision at the administrative review conference is adverse to the provider, a request for a fair hearing may be made in accordance with the Administrative Procedure Act, Wash. Rev. Code, Sec. 34.04. *Id.*

WEST VIRGINIA

Hospital (Department of Human Services, Medicaid Program Regulations, Chapter 700). State Medicaid Program regulations (applicable to all Medicaid providers) permit a provider to obtain administrative review through an "informal conference," during which the provider may present its case, provide additional information bearing on administrative action, or receive clarification or explanation of relevant policy. *Id.* at Sec. 764, p. 5. If dissatisfied, the provider may proceed to a formal hearing where the findings of fact and conclusions of law arrived at below may be challenged. *Id.* at Sec. 765.1, p. 6. Judicial review of this decision is available. *Id.* at Sec. 765.3, p. 6.

Nursing Home (Attachment 4.19-D, TN 86-7). The Plan contains only an assurance that there is an appeals or exceptions procedure for review of payment rates that allows individual providers to submit additional information and receive prompt administrative review. *Id.* at 7.

The Medicaid regulations described above also apply to nursing homes.

WISCONSIN

Hospital (Attachment 4.19-A) The Plan assures that the State provides an appeal mechanism that allows providers the opportunity to submit additional evidence and to request prompt administrative review of payment rates. *Id.* at 1. A hospital may seek a rate adjustment only for inappropriate calculation of rates (including clerical errors) or significant change in patient mix to include more low-income patients. *Id.* at 16. The Plan defines "inappropriate calculation of rates" to mean the application of the ratesetting methods to incomplete or incorrect data. *Id.*

Nursing Home (Attachment 4.19-D, TN 89-0011). The Plan provides that a Nursing Home Appeals Board is available for redress in the event that a facility has extraordinary fiscal circumstances. *Id.* at Sec. 1.400. Providers also are permitted to appeal a final ratesetting action. *Id.* at Sec. 1.700. The Plan further provides that a nursing home may request an administrative review of cost-finding decisions. *Id.* at Sec. 1.800.

WYOMING

HCFA's copies of the Plan contain no provision for rate-related appeals by hospitals or nursing homes. The State's Rules for Medicaid Administrative Hearings are separately printed, and apply to all Medicaid providers. Providers may appeal "adverse actions." *Id.* at Sec. 4(a), p. 1. The rules specifically state that the term adverse action "does not include an appeal of ratesetting methodology." *Id.*

APPENDIX B

Classification of Procedures for Rate-Related Appeals By Medicaid Providers

In this Appendix, *amici* classify the procedures for rate-related appeals by Medicaid providers (hospitals and nursing homes) according to a number of relevant categories. States in which the procedure contains limitations fitting more than one category are listed only once, and the States in which we were unable to locate a procedure (hospital: New Hampshire, North Dakota) are not included. More detailed information on the rules of each jurisdiction and citations to these rules are furnished in Appendix A.

I. States In Which Appeals Are Limited To Correction Of Errors Or Changed Circumstances

Limitation	States	Total Hospital	Total Nursing Home
A. Audit adjustments to or factual findings in cost reports, errors in calculation or computation			
1. Hospital	Florida, Illinois*, Indiana, Massachusetts*, Mississippi*, Montana, New York*, Tennessee*, Washington*, Wisconsin*	10	
2. Nursing Home	Alabama, Florida, Maryland, Nebraska, Nevada, New York*, South Carolina, South Dakota, Texas, Vermont, Wisconsin*		11
B. Changed circumstances (patient case-mix, new services or capital expenditures, extraordinary circumstances) since base year			
1. Hospital	Arkansas, Colorado, Kansas, Kentucky, Maryland, New Mexico	6	
2. Nursing Home	Kansas		1
TOTALS		16	12

* Indicates procedure permits appeals under both A and B.

II. States In Which Appeals Of Rate Methodology Specifically Prohibited

Limitation	States	Total Hospital	Total Nursing Home
A. No appeal of principles of reimbursement or rate methodology			
1. Hospital	Alabama, Idaho, Michigan, Ohio, Pennsylvania, South Carolina, Texas, Wyoming	8	
2. Nursing Home	Idaho, Michigan, Pennsylvania, Virginia, Wyoming		5
B. No appeal of key elements of rate methodology (e.g., inflation factor or rate ceilings)			
1. Hospital	California, Hawaii, Missouri, North Carolina, Rhode Island, Virginia	6	
2. Nursing Home	California, Hawaii, Missouri, North Carolina		4
C. Appeals limited to determining conformity of rate with established methodology			
1. Hospital	New Jersey, Georgia	2	
2. Nursing Home	Indiana, Maine, Massachusetts, Mississippi, New Jersey, New Mexico		6
D. Appeals limited to contests to application or interpretation of established methodology			
1. Nursing Home	Colorado, New Hampshire, Kentucky, Rhode Island		4
TOTALS		16	19

III. States In Which Particular Limitations Preclude Challenges To Ratesetting Methodology

Limitation	States	Total	
		Hospital	Nursing Home
A. Appeals must be brought within specified time of adverse action			
1. Nursing Home	Arkansas		1
B. Appeals must identify particular computations and adjustments contested			
1. Hospital	Nevada	1	
2. Nursing Home	North Dakota, Utah		2
TOTALS		1	3

IV. States In Which Procedures Limited To Appeal Of Rates Or Rate Determinations

Limitation	States	Total	
		Hospital	Nursing Home
A. Provider permitted to present new evidence and receive review of payment rates			
1. Hospital	District of Columbia, Maine, Nebraska, Oklahoma, South Dakota, Utah	6	
2. Nursing Home	Louisiana, West Virginia		2
B. Provider permitted to appeal rate or rate determination			
1. Hospital	Iowa, Louisiana, Oregon, Vermont	4	
2. Nursing Home	District of Columiba, Georgia, Illinois, Montana, Oklahoma, Oregon, Tennessee, Washington		8
TOTALS		10	10

V. States In Which Appeal Of Rate Methodology May Be Permitted By Rule

Rule	States	Total	
		Hospital	Nursing Home
A. Provider may appeal action or decision of rate commission			
1. Hospital	Alaska, Arizona, Connecticut, Delaware, Minnesota	5	
2. Nursing Home	Alaska, Arizona, Connecticut, Delaware		4
B. Provider may appeal validity or legality of rule			
1. Hospital	West Virginia	1	
2. Nursing Home	Iowa, Minnesota		2
C. Provider may appeal administrative action not otherwise provided for by letter			
1. Nursing Home	Ohio	—	1
TOTALS		6	7

APPENDIX C

List of Reported Federal Cases in Which Violations of The Boren Amendment Have Been Alleged [1]

AMISUB (PSL) v. Colorado Dept. of Social Services, 879 F.2d 789 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682);

Hoodkroft Convalescent Center Inc. v. New Hampshire Division of Human Services, 879 F.2d 968 (1st Cir. 1989);

West Virginia Univ. Hosps. Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989);

Colorado Health Care Ass'n v. Colorado Dep't of Social Services, 842 F.2d 1158 (10th Cir. 1988);

Wisconsin Ass'n v. Revitz, 820 F.2d 863 (7th Cir. 1987);

Wilmac Corp. v. Bowen, 811 F.2d 809 (3d Cir. 1987);

Coos Bay Care Center v. Oregon Dep't of Human Resources, 803 F.2d 1060 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036, *vacated as moot*, 484 U.S. 806 (1987);

Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987);

United Hosp. Center, Inc. v. Richardson, 757 F.2d 1445 (4th Cir. 1985);

Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services, 733 F.2d 1224 (7th Cir. 1984);

Oberlander v. Perales, 740 F.2d 116 (2d Cir. 1984);

Alabama Hosp. Ass'n v. Beasley, 702 F.2d 955 (11th Cir. 1983);

Mississippi Hosp. Ass'n, Inc. v. Heckler, 701 F.2d 511 (5th Cir. 1983);

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[1] Based on a search of West's Federal Reporters, the Medicare & Medicaid Guide (CCH), WESTLAW, and LEXIS.

Hadley Memorial Hosp. Inc. v. Schweiker, 689 F.2d 905 (10th Cir. 1982);

Washington State Health Facility Ass'n v. Washington Dep't of Social and Health Services, 698 F.2d 964 (9th Cir.1982);

Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (4th Cir. 1982);

Chicago Osteopathic Medical Centers v. Duffy, No. 88-C-1174 (N.D. Ill. Oct. 27, 1989) (WESTLAW, Allfeds database);

Pinnacle Nursing Home v. Axelrod, 719 F. Supp. 1173 (W.D.N.Y. 1989);

Illinois Health Care Ass'n v. Suter, 719 F. Supp. 1419 (N.D. Ill. 1989);

AGI-Bluff Manor, Inc. v. Reagen, 713 F. Supp. 1535 (W.D. Mo. 1989);

In re Saint Joseph's Hosp., 103 Bankr. 643 (Bankr. E.D. Pa. 1989);

SSM Healthcare Systems v. Reagen, 681 F. Supp. 625 (W.D. Mo. 1988);

Friedman v. Perales, 668 F. Supp. 216 (S.D.N.Y. 1987), *aff'd* 841 F.2d 47 (2d Cir. 1988);

Vantage Healthcare v. Virginia Board of Medical Assistance Services, 684 F. Supp. 1329 (E.D. Va. 1988);

St. Tammany Parish Hosp. Service Dist. v. Dep't of Health and Human Resources, 677 F. Supp. 455 (E.D. La. 1988);

Bethany Medical Center v. Harder, 693 F. Supp. 968 (D. Kan. 1988), *opinion amended*, No. Civ. A. 85-2415-0 (D. Kan. July 1, 1988);

Montoya v. Johnston, 654 F. Supp. 511 (W.D. Tex. 1987);

Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985);

Arden House, Inc., v. Heintz, 612 F. Supp. 81 (D. Conn. 1985);

Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services, 634 F. Supp. 1313 (E.D. Wis. 1986);

Friedman v. Perales, 616 F. Supp. 1363 (S.D.N.Y. 1985);

Hilburn v. Commissioner, Connecticut Dep't of Income Maintenance, No. H-82-200 (D. Conn. July 17, 1985) (WESTLAW, Allfeds database);

Florida Nursing Home Ass'n v. Paige, 596 F. Supp. 1152 (S.D. Fla. 1984);

Illinois Council on Long Term Care v. Miller, 579 F. Supp. 1140 (N.D. Ill. 1983);

Troutman v. Cohen, 588 F. Supp. 590 (E.D. Pa. 1984), *aff'd*, 755 F.2d 924 (3d Cir. 1984);

In re Greenwald, 48 Bankr. 263 (S.D.N.Y. 1984);

Illinois Council on Long Term Care v. Coler, Nos. 83-C-4812, 83-C-5245, 83-C-6574 (N.D. Ill. Sept. 24, 1984) (WESTLAW, Allfeds database);

New York City Health and Hosps. Corp. v. Heckler, 593 F. Supp. 226 (S.D.N.Y. 1984);

Fort Tryon Nursing Home v. Perales, 592 F. Supp. 819 (S.D.N.Y. 1984);

California Ass'n of Bioanalysts v. Rank, 577 F. Supp. 1342 (C.D. Cal. 1983);

In re Park Nursing Center, Inc., 28 Bankr. 793 (Bankr. E.D. Mich. 1983);

Thomas v. Johnston, 557 F. Supp. 879 (W.D. Tex. 1983);

Children's Hosp. of Philadelphia v. Secretary of Dep't of Public Welfare, 568 F. Supp. 1001 (E.D. Pa. 1983);

Michigan Hosp. Ass'n v. Department of Social Services, 555 F. Supp. 675 (E.D. Mich. 1983);

Children's Memorial Hosp. v. Illinois Dep't of Public Aid, 562 F. Supp. 165 (N.D. Ill. 1983);

California Hosp. Ass'n v. Schweiker, 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983);

Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid, 576 F. Supp. 360 (N.D. Ill. 1983);

Coalition of Michigan Nursing Homes, Inc. v. Dempsey, 537 F. Supp. 451 (E.D. Mich. 1982);

Massachusetts Hospital Ass'n, Inc. v. Harris, 500 F. Supp. 1270 (D. Mass. 1980).

APPENDIX D

Listing of Additional *Amici Curiae*

Affiliates of the American Health Care Association:

Alabama Nursing Home Association
Health Association of Alaska
Arizona Health Care Association
Arkansas Health Care Association
California Association of Health Facilities
Colorado Health Care Association
Connecticut Association of Health Care Facilities
Delaware Health Care Facilities Association
District of Columbia Health Care Association
Florida Health Care Association
Georgia Health Care Association
Healthcare Association of Hawaii
Idaho Health Care Association
Illinois Health Care Association
Indiana Health Care Association
Iowa Health Care Association
Kansas Health Care Association
Kentucky Association of Health Care Facilities
Louisiana Health Care Association
Maine Health Care Association
Health Facilities Association of Maryland
Massachusetts Federation of Nursing Homes, Inc.
Health Care Association of Michigan
Care Providers of Minnesota
Mississippi Health Care Association
Missouri Health Care Association
Montana Health Care Association
Nebraska Health Care Association
Nevada Health Care Association
New Hampshire Health Care Association
New Jersey Association of Health Care Facilities
New Mexico Health Care Association
New York State Health Facilities Association
North Carolina Health Care Association

North Dakota Long Term Care Association
Ohio Health Care Association
Oklahoma Nursing Home Association
Oregon Health Care Association
Pennsylvania Health Care Association
Rhode Island Health Care Association
South Carolina Health Care Association
South Dakota Health Care Association
Tennessee Health Care Association
Texas Health Care Association
Utah Health Care Association
Vermont Health Care Association
Washington Health Care Association
West Virginia Health Care Association
Wisconsin Association of Nursing Homes
Wyoming Health Care Association

Affiliates of the American Association of Homes for the Aging:

Arizona Association of Homes for the Aging
Association of Massachusetts Homes for the Aging
Association of Ohio Philanthropic Homes and Housing for Aging
California Association of Homes for the Aging
Colorado Association of Homes and Services for the Aging
Connecticut Association of Non-Profit Facilities for Aged
Florida Association of Homes for the Aging
Georgia Association of Homes and Services for the Aging
Illinois Association of Homes for the Aging
Indiana Association of Homes for the Aging
Iowa Association of Homes for the Aging
Kansas Association of Homes for the Aging
Kentucky Association of Homes for the Aging
Louisiana Association of Homes and Services for Aging

Maryland Association of Non-Profit Homes for the Aging.
Michigan Non-Profit Homes Association
Minnesota Association of Homes for the Aging
Missouri Association of Homes for the Aging
Montana Association of Homes for the Aging
Nation's Capital Area Association of Homes for the Aging
New Jersey Association of Non-Profit Homes for the Aging
New York Association of Homes and Services for the Aging
North Carolina Association of Non-Profit Homes for the Aging
North Dakota Nursing Home Association
Oregon Association of Homes for the Aging
Pennsylvania Association of Non-Profit Homes for the Aging
Rhode Island Association of Facilities for the Aged
South Dakota Association of Homes for the Aging
Texas Association of Homes for the Aging
Virginia Association of Nonprofit Homes for the Aging
Washington Association of Homes for the Aging
Wisconsin Association of Homes and Services for the Aging